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IS IT POSSIBLE TO INCREASE THE QUALITY OF SEXUAL LIFE AFTER SPONTANEOUS BIRTH?

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ABSTRACT

The decrease in number of vaginal births may also be due to the discomfort caused by the episiotomy wounds.

Episiotomy wounds are characterized by discomfort, stinging, vulvodynia.

The decrease in immunity, the increase in vaginal pH during pregnancy and pregnancy, can cause the appearance of bacterial vulvovaginitis and can lead to poor healing of the episiotomy wound.

The patients will be initially evaluated by means of a questionnaire at 24 hours postpartum and then reevaluated at 7 days, when the suture material is removed, by completing the same questionnaire. Bacteriological vaginal secretion examination will also be collected both at 24 hours postpartum and at 40 days.

Visual scales will also be used (REEDA scale, VANCOUVER), at 7 days and at 40 days.

Thus, starting from the question, is postpartum sexual life influenced by episiotomy wounds, we will try to find an answer to this question by applying a questionnaire prepared by us.

Keywords: quality of life, postpartum, sexual life, birth

Introduction

Vaginitis during pregnancy may influence the outcome of the pregnancy with several consequences such as preterm labor, chorioamnionitis, premature rupture of the membranes, neonatal infection and postpartum endometritis (1).

The most common causes of vaginitis are bacterial vaginosis, vulvovaginal candidiasis, and trichomoniasis. Bacterial vaginosis is implicated in 40% to 50% of cases when a cause is identified, with vulvovaginal candidiasis accounting for 20% to 25% of cases, while trichomoniasis stands for 15% to 20% of cases (2).

Non-infectious causes may include atrophic vaginitis, irritant, allergic, and inflammatory vaginitis; this kind of vaginitis are less common and account about 5- 10% of vaginitis cases (2).

Bacterial vaginosis is a pathology caused by the modification of the vaginal microbiome, characterized by the excessive development of some bacteria considered mostly saprophytic, but which, through excessive reproduction, lead to a decrease in the number of lactobacilli in the Doderlein complex (3).

Bacterial Vaginosis is thought to arise from anaerobic vaginal flora replacing aerobic vaginal flora, namely lactobacilli. Anaerobe

bacteria responsible for this alteration may include Bacteroides, Gardnerella Vaginallis, Mycoplasma Hominis, Pepto streptococcus Spiralis or Mobiluncus Spiralis. These organisms and their alteration of flora are thought to both irritate the patient symptomatically, manifesting as a vaginitis, as well as trigger the mucosal immune system (4).

The mechanisms of Bacterial Vaginosis pathophysiology are not well understood, but a protective role for H2O2-producing Lactobacillus against colonization by catalase-negative anaerobic bacteria has been recognized (4).

Multiple behavioral factors have been hypothesized as increasing risk for bacterial vaginosis infection, including increased frequency of douching, lower socioeconomic status, coital frequency and use of vaginal products (5) (6).

Population studies have led to the identification of African American background as having a 3-fold increased risk compared with Caucasians. Paternal race was recently identified as an independent risk factor for bacterial vaginosis infection during pregnancy (7).

The main medication for treatment in bacterial vaginosis during and outside of pregnancy have been metronidazole and clindamycin. The Center for Disease Control and Prevention (CDC) suggest either drug in oral or vaginal preparation (8). The two drugs are considered clinically equivalent. Yet, they produce different antibiotic resistance profiles among anaerobic bacteria colonizing the vaginal birth canal following administration. (9)

If the mother is allergic to metronidazole, alternative antibiotics like Clindamycin may be prescribed. Another drug used is Tinidazole which is similar to metronidazole and is also effective in treating trichomoniasis vaginitis during pregnancy (10).

Yeast infections are caused by the overgrowth of a fungus called Candida albicans. These are verry common during pregnancy and postpartum due to hormonal changes, increased blood sugar levels in the vagina, and weakened immune systems (11).

The symptoms of yeast infections include a thick, white discharge with a cottage cheese-like texture, burning, soreness, and itching (12). Untreated yeast infections during pregnancy may lead to preterm labor, as well as the risk of passing the infection to the baby during delivery (13).

The recommended treatment for yeast infections during pregnancy is topical antifungal medications, such as clotrimazole, miconazole, or butoconazole. Prospective and observational studies involving the use of topical antifungals did not reveal an increased risk of major malformations when mothers were exposed any time during pregnancy, and the authors considered them generally safe. Systemic absorption of these topical medications is minimal, posing little risk of transfer to the unborn baby (14).

The Pelvic Organ Prolapse/Urinary Incontinence Sexual Questionnaire (PISQ-12) is a validated condition-specific quality of life questionnaire. The International Continence Society recommends this questionnaire with grade A to assess sexual function with urinary symptoms (15).

PISQ-12 is a self-administered questionnaire, where responses are graded on a five-point scale ranging from 0 (always) to 4 (never) on items 5 to 12. Items 1 – 4 are reversely scored, 0 (never) to 4 (always). A total of 48 points is the maximum score. The higher scores indicate better sexual function (16).

Material and Methods

Using PISQ Test Post-Partum adapted

The study was carried out over a period of 3 months, from 1st of January 2023 to 31 March 2023. The questionnaire was created, starting from PISQ-12 questionnaire which was adapted for postpartum period. The PISQ-12 Questionnaire was first adapted to puerperium period and then it was adapted to Romanian language.

The study included patients hospitalized at Saint Andrew the Apostle University Hospital, Clinical Departments of Obstetrics and Gynecology I and II, who were primiparas and gave birth by vaginal way having an episiotomy wound.

PICO criterias (Population, Intervention, Comparison, Outcomes) were applied. This study

was a prospective, experimental and analytical, study. To avoid bias, randomization was used to split the studied lots.

The patients who were part of this study were primiparous patients with a gestational age between 28- 40 weeks of gestation.

They study group was sorted in 2 groups of patients. The first group consisted of patients who had no history of vaginal delivery - intact perineum - 10 patients (Group A)- experimental batch. The second group consisted of patients who had no history of vaginal delivery - intact perineum - 10 patients (Group B)- control batch.

A gel containing lactic acid and collagen was applied in group A patients and the group was compared with a control group B of patients to whom the substance was not applied.

The patients included in the study, were hospitalized patients who completed the birth at the Constanta County Hospital, who gave their consent to participate in this study.

The study was based on a study protocol (inclusion criteria, exclusion criteria and informed consent).

The patients were initially evaluated by means of a consent at 24h postpartum and then reevaluated at 7 days, when the suturing material was removed.

Bacteriological vaginal secretion was collected at 24 hours postpartum and 40 days later.

We used REEDA visual scale at 7 days and at 40 Days after birth.

When patients started again their sexual life, they self-completed the questionnaire, and the questionnaire was interpreted by a statistician.

Like PISQ-12 score, responses were graded on a five-point Likert scale ranging from 0 (always) to 4 (never) to items 5 to 12. Items 1 to 4 were reversely scored from 0 (never) to 4 (always).

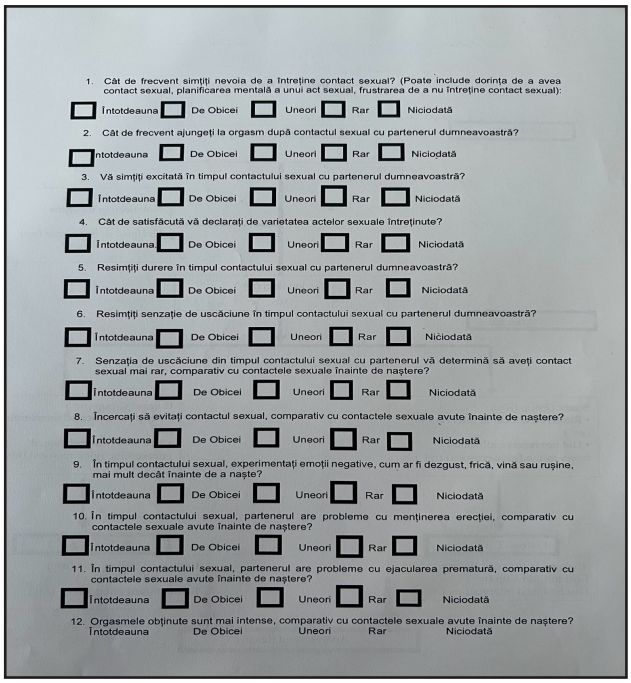

1. Cât de frecvent simțiți nevoia de a întreține contact sexual? (Poate include dorința de a avea contact sexual, planificarea mentală a unui act sexual, frustrarea de a nu întreține contact sexual):
Întotdeauna De Obicei Uneori Rar Niciodată
2. Cât de frecvent ajungeți la orgasm după contactul sexual cu partenerul dumneavoastră?
Întotdeauna De Obicei Uneori Rar Niciodată
3. Vă simțiți excitată în timpul contactului sexual cu partenerul dumneavoastră?
Întotdeauna De Obicei Uneori Rar Niciodată
4. Cât de satisfăcută vă declarați de varietatea actelor sexuale întreținute?
Întotdeauna De Obicei Uneori Rar Niciodată
5. Resimțiți durere în timpul contactului sexual cu partenerul dumneavoastră?
Întotdeauna De Obicei Uneori Rar Niciodată
6. Resimțiți senzație de uscăciune în timpul contactului sexual cu partenerul dumneavoastră?
Întotdeauna De Obicei Uneori Rar Niciodată
7. Senzația de uscăciune din timpul contactului sexual cu partenerul vă determină să aveți contact sexual mai rar, comparativ cu contactele sexuale înainte de naștere?
Întotdeauna De Obicei Uneori Rar Niciodată
8. Încercați să evitați contactul sexual, comparativ cu contactele sexuale avute înainte de naștere?
Întotdeauna De Obicei Uneori Rar Niciodată
9. În timpul contactului sexual, experimentați emoții negative, cum ar fi dezgust, frică, vină sau rușine, mai mult decât înainte de a naște?
Întotdeauna De Obicei Uneori Rar Niciodată
10. În timpul contactului sexual, partenerul are probleme cu menținerea erecției, comparativ cu contactele sexuale avute înainte de naștere?
Întotdeauna De Obicei Uneori Rar Niciodată
11. În timpul contactului sexual, partenerul are probleme cu ejacularea prematură, comparativ cu contactele sexuale avute înainte de naștere?
Întotdeauna De Obicei Uneori Rar Niciodată
12. Orgasmele obținute sunt mai intense, comparativ cu contactele sexuale avute înainte de naștere?
Întotdeauna De Obicei Uneori Rar Niciodată

Figure 1. PISQ-12- Puerperium adapted Romanian translated score

Results and discussions

The batch A, who used lactic acid and collagen applications, mean score, was 39.9, while the batch B, which was in control group was 31.9 (Table 1, Table 2). A possible explication may be the usage of the lactic acid and collagen gel which improved the puerperium vaginosis status and improved the quality of episiotomy wound scarification.

The included patients number was a small one, with only 10 patients on the study group and only 10 patients on the control group. For a statistic significance, and a validity of the PISQ-12- PUERPIRIUM ADAPTED, we intend in the future too extend the study.

We also created a study protocol to be used by clinicians in order to give our study reproducibility.

According to some statistics, caesarean section represents the second most common

Table 1- Batch A patients' responses

P1EG	P2EG	P3EG	P4EG	P4EG	P5EG	P6EG	P7EG	P8EG	P9EG
42	42	37	39	40	39	35	41	40	44

Table 2- Batch B patients' responses

P1CG	P2CG	P3CG	P4CG	P4CG	P5CG	P6CG	P7CG	P8CG	P9CG
35	32	32	33	31	33	30	31	32	30

surgical procedure, first one being the cataract surgery, Romania occupying a leading place in this unpleasant statistic with around 44% incidence.

The incidence of Caesarean Section in our hospital, in the last 5 years was 44,45%. The WHO target for the future years is to drop the incidence of caesarean section to around 10-15% and we hope that by decreasing the unpleasant symptoms of episiotomy wound and by increasing the quality of sexual life, to decrease the rate of caesarean section.

References

1. Faro S. Vaginitis and pregnancy. J Reprod Med. 1989 Aug;34(8 Suppl):602-4.
2. Paladine HL, Desai UA. Vaginitis: Diagnosis and Treatment. Am Fam Physician. 2018 Mar 1;97(5):321-9.
3. Russo R, Karadja E, De Seta F. Evidence-based mixture containing Lactobacillus strains and lactoferrin to prevent recurrent bacterial vaginosis: a double blind, placebo controlled, randomised clinical trial. Benef Microbes. 2019 Feb 8;10(1):19-26.
4. Spiegel CA. Bacterial vaginosis. Clinical Microbiology Reviews. 1991;4(4):485-502.
5. Zhang J, Hatch M, Zhang D, Shulman J, Harville E, Thomas AG. Frequency of douching and risk of bacterial vaginosis in African-American women. Obstet Gynecol. 2004 Oct;104(4):756-60.
6. Verstraelen H, Verhelst R, Vaneechoutte M, Temmerman M. The epidemiology of bacterial vaginosis in relation to sexual behaviour. Bmc Infect Dis. 2010 Mar 30;10:81.
7. Simhan HN, Bodnar LM, Krohn MA. Paternal race and bacterial vaginosis during the first trimester of pregnancy. Am J Obstet Gynecol. 2008 Feb;198(2):196 e1-4.
8. Centres for disease Control and Prevention. Bacterial Vaginosis. CDC; 2021 [cited 2023]; Available from: https://www.cdc.gov/std/treatment-guidelines/bv.htm.
9. Denney JM, Culhane JF. Bacterial vaginosis: a problematic infection from both a perinatal and neonatal perspective. Semin Fetal Neonatal Med. 2009 Aug;14(4):200-3.
10. Workowski KA, Bolan GA. Sexually transmitted diseases treatment guidelines, 2015. MMWR Recomm Rep. 2015 Jun 5;64(Rr-03):1-137.
11. Monif GR, Baker DA. Candida albicans. In: R MG, A BD, editors. Infectious diseases in obstetrics and gynecology. New York: Partheon Press; 2003. p. 405-21.
12. Institute for Quality and Efficiency in Health Care (IQWiG). Vaginal yeast infection (thrush): Overview. 2006 [updated 2019]; Available from: https://www.ncbi.nlm.nih.gov/books/NBK543220/.
13. Chan MY, Smith MA. 5.16 - Infections in Pregnancy. In: McQueen CA, editor. Comprehensive Toxicology (Third Edition). Oxford: Elsevier; 2018. p. 232-49.
14. Soong D, Einarson A. Vaginal yeast infections during pregnancy. Can Fam Physician. 2009 Mar;55(3):255-6.
15. ‘t Hoen LA, Utomo E, Steensma AB, Blok BFM, Korfage IJ. The Pelvic Organ Prolapse/Urinary Incontinence Sexual Questionnaire (PISQ-12): validation of the Dutch version. International Urogynecology Journal. 2015 2015/09/01;26(9):1293-303.
16. Rogers RG, Coates KW, Kammerer-Doak D, Khalsa S, Qualls C. A short form of the Pelvic Organ Prolapse/Urinary Incontinence Sexual Questionnaire (PISQ-12). Int Urogynecol J Pelvic Floor Dysfunct. 2003 Aug;14(3):164-8; discussion 8.