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CASE REPORT PAIN MANAGEMENT

Allodynia at episiotomy scar as an unusual cause for dyspareunia: a case report

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ABSTRACT

Even though an episiotomy, a common perineal incision made during childbirth, is intended to prevent perineal trauma, significant postpartum complications such as perineal pain and dyspareunia may occur by it.

We describe a case of a 45-year-old mother of two children, who presented with superficial dyspareunia affecting her sexual and social relationships. Despite normal ultrasound and abdominal examination findings, allodynia at the site of a previous episiotomy scar was found during the perineal examination. Surgical excision was performed as conventional analgesics and lidocaine provided inadequate pain relief. The efficacy of surgical intervention is underscored by the non-recurrence of dyspareunia over a one-year follow-up period.

The importance of a thorough evaluation in diagnosing dyspareunia and multidisciplinary approach in management are highlighted in this case report, as pain sources may not be immediately apparent.

Keywords: episiotomy scar; allodynia; postpartum dyspareunia; perineal pain.

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1. INTRODUCTION

Dyspareunia, defined as painful sexual intercourse, is a condition with potential aetiologies ranging from physiological to psychological factors.[1] It is a significant clinical concern that can arise from various causes, one of which is the episiotomy, a routine perineal incision made during childbirth.[2] While an episiotomy intends to prevent severe perineal trauma, it can result in perineal pain and dyspareunia postpartum.[3] Allodynia is the experience of pain from stimuli that are not typically painful. Although allodynia at surgical scar sites is rarely discussed in the literature, it can be a troubling consequence for patients, impacting their quality of life and sexual function. The incidence of dyspareunia, especially from the episiotomy scar, is not well-documented. Scar endometriosis, a rare condition where endometrial tissue grows into the episiotomy scar, has been reported to cause significant morbidity, including pain and dyspareunia.[4,5] Treatment options for dyspareunia related to episiotomy scars include medical

management and physiotherapy. In cases of scar endometriosis, surgical excision of the lesion has shown effective outcomes.[1,6] While dyspareunia is a well-recognized condition, its association with allodynia at episiotomy scar sites requires further investigation. The available literature suggests that when dyspareunia is related to scar endometriosis, surgical intervention is often necessary and effective in providing relief.[1,5,6] This case report will explore the presentation, diagnosis, and management of dyspareunia arising from an episiotomy scar site, contributing to understanding post-surgical allodynia and its treatment options.

2. CASE REPORT

A 45-year-old mother of two presented with superficial dyspareunia, which had prevented deep penetration for the past two years. She did not experience pain at rest but reported aching pain during attempts at sexual intercourse. The patient also faced social and relationship issues due to the persistent pain. She had two previous normal vaginal deliveries, the last one three years ago.

Upon examination, no abnormalities were found in the genital tract, and an ultrasound scan showed a normal-sized uterus with no abnormalities. Her menstrual history was unremarkable. However, a perineal examination revealed a painful point at the site of a previous episiotomy scar, suggestive of allodynia rather than true pain. A deep vaginal examination using cotton wool revealed no deep pain.

The patient was initially treated with conventional analgesics and lidocaine gel. Due to a poor response to these medications, excision of the episiotomy scar was subsequently performed. The patient was followed up in the clinic for a year. Since there were no episodes of dyspareunia during this time, she was discharged from follow-up.

3. DISCUSSION

Allodynia, the experience of pain from stimuli that are not normally painful, at a previous episiotomy scar is an uncommon but noteworthy cause of dyspareunia. Dyspareunia after vaginal delivery is a multifaceted issue with various contributing factors, including physical trauma to the perineum, psychological factors, and the healing process post-delivery.

The literature presents a range of findings on the subject of dyspareunia following vaginal delivery. Studies have shown that women who underwent episiotomy reported higher frequencies of dyspareunia and insufficient lubrication compared to those who did not have the procedure.[7] This suggests that the episiotomy itself may be a risk factor for long-term sexual dysfunction. However, the type of episiotomy performed—mediolateral or lateral—does not appear to significantly affect sexual function outcomes, including dyspareunia, in the months following childbirth.[8] Our patient developed dyspareunia about a year after her last vaginal delivery, and the incision was a lateral episiotomy.

Interestingly, another study found no correlation between late postpartum dyspareunia and the mode of delivery or the state of the perineum, including perineal laceration or episiotomy. This indicates that other factors, such as previous sexual pain experiences and psychological aspects of childbirth, may play a more significant role.[9]

The occurrence of allodynia at an episiotomy scar can be particularly distressing, as it may affect not only sexual function but also general comfort and quality of life. In our patient, the condition affected her sexual life as well as her social relationships.

Case reports of endometriosis in episiotomy scars,[4,10] highlight the potential for scar tissue to develop into a site of chronic pain and the importance of considering this in the differential diagnosis of perineal pain and dyspareunia. Moreover, the presence of endometriosis in such scars, although rare, underscores the complexity of postpartum pelvic pain and the need for careful evaluation. Our patient did not have any features suggestive of endometriosis before or after pregnancy, making it unlikely that this allodynia is secondary to endometriosis.

The management of dyspareunia and allodynia at an episiotomy scar may involve a multidisciplinary approach, including gynecological assessment, pain management, and physiotherapy, as indicated by the case of a patient benefiting from urogynecological physiotherapy for pain associated with the episiotomy scar. The importance of a comprehensive history and meticulous pelvic examination is emphasized in the diagnosis of perineal endometriosis, which can present similarly to allodynia at an episiotomy scar.[5] Therefore, it is crucial to rule out such conditions in these patients. An extensive examination, including an ultrasound scan, ruled out the presence of endometriosis.

In summary, allodynia at an episiotomy scar is a rare but important consideration in the differential diagnosis of postpartum dyspareunia. A holistic approach to management, incorporating a thorough clinical evaluation and a multidisciplinary treatment strategy, is essential for addressing this condition. Further research into the long-term outcomes of episiotomy and the development of allodynia at the scar site is warranted to improve care for affected women.

4. CONCLUSION

This case highlights the importance of a thorough examination in cases of dyspareunia, as the source of pain may not always be easily identifiable. In this instance, the presence of allodynia at the episiotomy scar site pointed to a localized source of pain. The successful outcome after scar excision underscores the significance of targeted interventions in managing chronic pain conditions, leading to an improved quality of life for the patient. A one-year follow-up revealed no recurrence of pain, suggesting the efficacy of the treatment approach taken.

5. Acknowledgements

None

6. Conflict of interest

Authors declare no conflict of interests.

7. Consent for publishing

Authors obtained written consent from the patient for publishing this case report.

8. Authors contribution

AR: Contributed in writing and revising the manuscript especially pain management related sections. Read and approved the final manuscript.

SG: Contributed in writing and revising the manuscript especially gynaecology related sections. Read and approved the final manuscript.

VT, SE: Contributed by gathering history from the patient and writing the manuscript. Read and approved the final manuscript.

GS: Contributed by writing and revising the manuscript. Read and approved the final manuscript.

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