Physiotherapy Management of Dyspareunia Associated with a Postpartum Vaginal Scar: A Case Report

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Introduction: Vaginal laceration is an injury to vaginal tissue that most commonly occurs during childbirth (1). Postpartum vaginal scars can contribute to dyspareunia (pain associated with penetration or sexual intercourse), as perineal and vaginal injuries are associated with pain and reduced sexual function. Dyspareunia affects approximately 20–40% of women during the first months postpartum (2) and can significantly affect sexual function and quality of life (3). Although obstetric vaginal injuries are common and associated with pain and dyspareunia (1, 2), the possibilities for physiotherapeutic management of these scars remain poorly investigated. The aim of this report is to present the effectiveness of the McLoughlin Scar Tissue Release (MSTR®) method in the management of a vaginal scar in a patient with isolated postpartum dyspareunia.

Case Description: A 32-year-old primiparous woman was treated for severe pain during deep penetration, which had been present since her first attempt at sexual intercourse following vaginal childbirth. During labour (induced labour, rapid second stage), she sustained a vaginal laceration that was surgically repaired. No perineal injury occurred.

Four months postpartum, sexual function was assessed using the Female Sexual Function Index (FSFI), with an initial score of 12/36. Pain was localised to the scar on the posterior vaginal wall (between the 4 and 7 o'clock positions) and was rated 6–9/10 on the Visual Analogue Scale (VAS).

A pulling or tightness sensation during daily activities was rare and occurred occasionally only when bending forward. Palpation revealed a poorly mobile scar and markedly reduced tissue elasticity at the site of the sutures. Pelvic floor muscle function was normal, and the patient reported no other pelvic floor dysfunctions.

Four MSTR® treatment sessions were performed, each lasting 45–60 minutes. Treatment was delivered intravaginally according to the standard protocol. However, due to the limited range of finger movement within the vagina, strokes were performed in the direction of the vaginal opening rather than in both directions.

Results: Following treatment, the FSFI score improved to 28/36, and pain completely resolved (VAS 0/10 in all positions). The pulling sensation was no longer present. On palpation, the scar remained palpable but was painless, softer and more elastic. Sexual intercourse was possible without pain. Improvement was gradual, with the greatest improvement observed after the first treatment. The patient reported no adverse effects during or after treatment. Written informed consent was obtained for publication of the case report.

Discussion: In this case, the patient reported reduced pain during sexual intercourse after manual treatment of the vaginal scar using the MSTR® method, with improvement already observed after the first session. Improvements in tissue mobility, elasticity and pain were expected and consistent with findings from studies reporting the effectiveness of manual therapy in scar management. A distinctive feature of this case was the absence of other

pelvic floor muscle dysfunctions, allowing the observed symptom improvement to be more directly associated with the physiotherapy intervention.

Conclusions: Manual treatment of a vaginal scar using the MSTR® method was associated with the resolution of dyspareunia symptoms and improved quality of life in the presented case.

Keywords: vaginal laceration, MSTR, postpartum period, sexual function, quality of life.

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