ANORGASMIA

Introduction

70% of women are more or less affected by orgasm problems [1] . However, this subject is treated relatively "as a watchword". Because behind the general term "orgasm problems" there is a whole series of problems: lack of sexual desire, vaginal dryness, poor excitability and pain during intercourse, which are further influenced by postpartum symptoms .

Therefore, it should not be assumed that orgasm problems are solitary, but general sexual dysfunction (FSD Female Sexual Dysfunction). Given the large number of influencing factors, it is difficult to find a universal treatment option, especially since female Viagra (Flibanserin / Pink-Viagra), launched in the United States, turned out to be a flop [3] . However, breaking down an FSD on pelvic floor function reveals an important treatment option.

Prevalence

In representative studies, 4-24% of women surveyed reported orgasm problems [4] , [5] , [6] . However, the surveys are not very meaningful, because the response rate, for example, in an exemplary survey (questionnaire) of almost 9,000 people was only about 56%. Women who were willing to compare their orgasm problems in their 30s with those in their 60s reported deterioration from 15.2% to 32.2% [7] . Other studies indicate that 42% of people surveyed have been unable to have an orgasm in the last few months [8] or the prevalence of female sexual dysfunction (FSD) should be 25–63% [9] .

In a nationally representative US-wide study using a telephone survey (women ages 30-70), age-related sexual interest decreased. As a result, the prevalence of women aged 60–70 was 61% [10] . According to a systematic review, 64% (16-75%) have problems with sexual desire, 35% (16-48%) have difficulty reaching orgasm and 31% (12-64%) have difficulty being sexually excited. and 26% (7–58%) reported pain during intercourse [11] .

When it comes to childbirth, 24% of women still report pain during intercourse even after 18 months [12] . According to another study, 77% of first-time mothers still complain of constant back pain a year after giving birth. Surprisingly, postpartum pelvic pain syndrome (PPS) not only affects vaginal deliveries [13] (40%), but also caesareans. Thus, the differences in prevalence between vaginal birth and operative birth are similar 6 to 11 years after delivery [14]. .

Pathogenesis

Basically, every person can reach an orgasm, which makes it easier for women to respond to interference [15] . How sensible it is to use an rPMS in case of female sexual dysfunction or in case of orgasm problem, decides above all whether the pelvic floor actually affects the discharge capacity. After evaluating a survey of 776 women and men from Hamburg and Leipzig, the female orgasm was no more complicated and difficult to achieve than the male. According to this, women could climax as surely as man [16] - at least by themselves (masturbation) - which ultimately goes against an organic cause.

It should be noted that women who have a "strong pelvic floor" in principle feel more sexual desire and a stronger orgasm [17] , [18] , [19] . Thus, the "sex pioneers" Masters & Johnson described a direct correlation between the strength of contractions of M. pubococcygeus (MPC) and ileococcygia (MICC) and the intensity of an orgasm [20] . However, the literature often speaks only of the "pelvic floor" without addressing individual muscle issues associated with sexual arousal or the entire orgasmic situation. It is indisputable that the pelvic floor muscles as a whole influence the sensory intensity of vaginal penetration [21] and that MPC and MIC are responsible for involuntary contractions during orgasm [22] , [23] .

However, this does not refer to the frequency of orgasm ("clitoral or vaginal"), for which confirmation is still lacking [24] . However, once the base of the clitoris is connected to the PPC, its only contraction may come from a physiological point of sexual arousal. The often coveted ischiocavernosus (MIC), often referred to as the "orgasmic muscle" in relevant literature, appears to be responsible only for the buildup of pressure in the clitoral cavernus. And the M. bulbospongiosus (MBS) compresses the dorsal vein so that it does not quickly drip into the erectile tissue - its pressure on the Bartholin glands located there enhances the lubrication of the vaginal entrance. Logically, the MICs and MBS are the most commonly injured muscles at birth. Of course, a general contraction of the pelvic floor always increases blood circulation and triggers tumescence of erectile tissue [25] . In conclusion, pelvic floor contraction intensifies arousal during sexual stimulation!

If one takes a closer look at the tonic-clonic contractions of the pelvic floor during an orgasm, each orgasm always seems very individual due to different vaginal anatomy ***[26] .*** However, it still depends on the quality of stimulation (of the partner) and, of course, muscle tone. The clitoral-urethro-vaginal union seems so robust that even after a clitectomy (surgical removal of the clitoris), it is still possible to invoke that orgasm through pelvic floor tension and subsequent discharge [27] . Even after complete spinal cord injury (above the pelvic and hypogastric nerves), women can still orgasm after genital stimulation [28] . Thus, the developer of Kegel training (pelvic floor training) is convinced that sexual sensation in the vagina is directly related to muscle tone and can be improved by strength training and resistance training of M. pubococygeus[29] .

Coital pain after previous deliveries [30] may be associated with inflammation [31] , [32] , to adhesions after surgery [33] , ovarian cysts,

an OAB [34] or even malformations of the genitals. However, there is often a so-called vaginismus, in which the muscles in the lower part of the vagina (probably due to mental illness) contract involuntarily, which makes penetration of the penis only possible under pain. This could be, for example, an attempt to compensate for weak fascia-ligamentous structures.

Cardiovascular stress, in turn, affects clitoral and vaginal blood flow, leading to loss of smooth muscle and vaginal dryness [35] . Diabetes mellitus also causes sequelae to nerves and vessels, which is directly perceptible in terms of sexual excitability and perception of pleasure. In addition, menopause (“estrogen deficiency”) has a relatively significant effect on all parameters of sexual dysfunction [36] . Finally, social factors should not be underestimated, a modern woman cannot fulfill her different roles of worker, housewife, mother, girlfriend and sex actress [37] .

Conservative therapies

For vaginal atrophy and reduced lubrication, the usual drug treatment attempt (“proven estrogen deficiency”) is local application of estrogen or sexual counseling. The bold hypothesis that it can solve up to 80% of all sexual and medical problems [38] is more wishful thinking than reality. Whether that will change anything with the approval of the melanocortin agonist Bremalanotid, is still completely open. Due to the various factors influencing DSE and the tiring procedure, active pelvic floor training (pelvic floor muscle training PFMT) is relatively rare or part of physiotherapeutic SUI or prolapse treatment positively influencing sexual dysfunction. [39] , confirmed by a systematic review [40] .

The quality of sexual sensation improved in 39% of women (control group 5%) after genital prolapse training at the pelvis [41] . Since the 1950s, the inventor of Kegel exercises has conducted (uncontrolled) studies that women who underwent pelvic floor training due to urinary incontinence often reported increased vaginal sensation and improved orgasm [42] , [43] . Kegel results are supported by a retrospective correlation study after M. pubococcygeus strength was consistently higher in orgasmic women than in women who cannot achieve orgasm [44] . This was confirmed by a controlled study that predicted the relationship between CPM strength and an orgasmic response [45]. .

Another study also shows that the likelihood of sexual activity is higher in women who have a strong pelvic floor ***[46] .*** For example, if pelvic floor training (twice a day for 10 weeks / Aukee incontinence protocol[47]) is performed, women in the active group significantly improve their sexual functions such as pleasure, arousal, lubrication, orgasm, coital satisfaction and pain. The overall score (FSFI) increased from 13 to 32 points, while it deteriorated from 15 to 13 in the control group [48] . Another study looked at women who suffered from decreased sexual desire and received PFMT for urinary incontinence. Thanks to the training, 30% of women lost their sexual desire, disappeared from all women suffering from coital pain and a third improved their problems with orgasm [49] . In

another literature review, at least the general trend was confirmed that in postpartum women, pelvic floor training can improve the sexual areas of arousal, lubrication, orgasm, and desire. However, the extent to which sexual pain may benefit is unclear [50]. .

Findings on electrical stimulation in sexual dysfunctions are understandably rare, as the introduction of an equally painful vaginal rod electrode finds only a few women interested. Although there are now electrical stimulation devices for home use. It's just how far can the M. iliococcygeus be trained here? A distinction must be made between sacral neurostimulation, which is useful in neurogenic disorders (MS, paraplegia, etc.). In a study that performed electrical stimulation over an 8-week period, but only once a week, desire, arousal, and orgasm improved. However, there were no changes in lubrication and coital pain in either group [51]. .

RPMS effect

The relevance of an rPMS in female sexual dysfunctions in terms of pleasure zones and orgasmic capacity essentially reveals a weakness of the pelvic floor and the clear results of the treatment of urinary incontinence, mainly muscle strengthening and recovery of representation cortical. In addition, the beneficial effects on sexual function studied in some studies (reviews) on the treatment of incontinence with pelvic pelvic rPMS [52] confirm the potential of rMSP treatment.

With regard to postpartum pain syndrome (coital pain/dyspareunia), which also strongly affects sexuality, there are also studies demonstrating the neuromodulation and training of insufficient or damaged muscles by means of rPMS[53] . , [54] , [55] . Animal experiments (mice) have shown that rPMS significantly minimizes inflammatory infiltrate and scarring of damaged muscles and not only prevents post-traumatic muscle atrophy, but also improves metabolism and d-receptor density. acetylcholine [56] .
Dyspareunia can also be caused by hypertension or permanent contraction of the pelvic floor muscles, independent of postpartum muscle damage [57]. , [58] , [59] . The results of active pelvic floor training here suggest [60] that an rMSP is also effective here.

Treatment scope / treatment period

In order to expand the cross-section of the pelvic floor muscles and intensify and expand the important cortical representation, rMPS training should be performed according to the treatment of SUI (2-3 times per week, 6- 8 weeks). The choice of frequency parameters here should be in the upper range. In the event of hypertonia of the pelvic floor leading to coital pain, about ten treatments are sufficient. To achieve muscle relaxation, it should be treated with low to medium frequency [61] .

Expectation of success

Based on the results of active pelvic floor training and the fact that rPMS exerts a much more intense effect, one can assume a significant increase in all sexual functions based on the SFSI score. An example of this is intensive home pelvic floor training under biofeedback control (twice a day for 10 weeks), in which there is an increase in sex score (from 1.2 to 4.8 points), 5.7), lubrication (1.95 to 5.4), satisfaction (2 to 5.6) and reduction in pain associated with coitus (4.6 to 5.68). The overall score went from 13.05 to 32.09, while in the control group it went from 15.32 to 13.67 [62] .

SFSI is a 19-item self-assessment tool that has been validated for women with arousal disorders, libido problems, orgasm disorders, etc. [63] , [64] . A score of 0 means the person has not had sex in the last few months.
A score ÿ 26.55 indicates sexual dysfunction in women [65] . This is also supported by studies, where rPMS training of the Pelvicenter QRS of the pelvic floor resulted in significant improvement in DSE in all sub-areas of the SFSI or GRISS score. Even after 3, 6 and 12 months after the end of treatment [66] , the result was kept.

Place of study

To date, two studies have been published on rPMS in female sexual dysfunction, but they do not explicitly refer to FSD, but also investigated the influence of rPMS on female sexual function in a treatment of incontinence (UI).

Study 1: Aim of the study: Influence of magnetic stimulation on stress incontinence and sexual function [67] . There were 39 sexually active women who were treated with rPMS twice a week (20 minutes) for 6 weeks. This resulted in a Success (SG) group with 64% of patients i.e. incontinence symptoms improved or healed and a Failure FG group did not respond to the treatment (36%).

Result:

After 3, 6 and 12 months, only the FG group achieved significant improvement in all areas of sexual dysfunction according to the FSFI score ($p<0.05$)

Study 2: Participation in treatment with the SMrPPelvicenter QRS of 66 married couples, whose sexually active partners (at least 21 years old) each suffered from stress incontinence (SUI) [68] . The standard period was 16 sessions (twice a week). Those who did not respond to treatment after 8 weeks could opt for an extension of 32 weeks. It was verified with the GRISS questionnaire (Golombok Rust Sexual Satisfaction Inventory) with both partners. It also contains 12 subscales such as erectile dysfunction (male), premature ejaculation (male), vaginismus (female), anorgasmia (female), lack of pleasure (male and female), sexual behavior avoidance (male and female), infrequent intercourse, and lack of sexual communication [69] .
Pelvic floor power was determined with a perinometer.

Result:

Six months after treatment, 53 of the couples (80.3%) were still available for the GRISS survey. Of the missing couples, 10 couples declined further investigation and 3 were no longer available. Shortly after treatment and 6 months later, there was significant improvement in SUI symptoms and pelvic floor function. Similarly, all sub-segments of the GRISS score improved significantly ($p<0.001$). This also involved the rare GV subscales, unsatisfaction, lack of ability to climax, and vaginismus – with improvement in "ungratification" being the most pronounced.

Conclusion

Sexual dysfunction, with a prevalence of 40–45%, is one of the most common, but often unsatisfied, conditions in women [70] . This is mainly referred to as "lack of desire" (64%) and "anorgasmia" (35%), followed by problems with sexual arousal and pain in the GV. Although partner issues, social conditions, deliverable consequences, or estrogen deficiency of menopause play an important role, a "strong pelvic floor" appears to be essential for sexual desire and the ability to orgasm. Here are mainly the Mm.pubococcygeus (MPC) and ileococcygeus (MICC), which are also responsible for the feeling of vaginal well-being and the rhythmic contractions of orgasm.

In the treatment of FSD, besides rather insignificant hormone replacement and couple therapy, the most effective of all, pelvic floor training cannot prevail. The most mundane reason is that most women avoid the tedious and strenuous training procedure of pelvic floor training or stray from it due to exertion.

With the rPMS QRS Pelvicenter, which is much more effective in increasing the size of the pelvic floor muscles and strengthening the important cortical representation, an effective and easy-to-use procedure is available, to which all parts of sexual dysfunction respond with a significant improvement! This also applies to vaginismus ("hypertonic pelvic floor") and postpartum coitus, especially since rPMS not only minimizes inflammatory infiltrates and scarring of damaged muscles, but also increases the density of muscle receptors for l acetylcholine.

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