

DIFFERENCES IN SEXUAL FUNCTION BETWEEN WOMEN AFTER CESAREAN SECTION WITH INDICATION OF SECOND STAGE DISTOCIA AND ELECTIVE INDICATION

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ABSTRACT

This research want to know the difference between a woman's sexual function after childbirth with Caesarean section on indications second stage dystocia and elective. This study is observational analytic with cross sectional design using comparative in M. Djamil General Hospital and Networking Hospital. Obtained samples are 26 women after childbirth caesarean section for second stage dystocia and 26 women after elective Caesarean section were spawned from term pregnancies that meet the inclusion and exclusion criteria. Data analysis was performed using univariate and bivariate using independent T test. The average female sexual function after caesarean section indication of second stage dystocia is $27,70 \pm 8,53$ and female sexual function after elective Caesarean section indications are $33,55 \pm 3,18$. Statistical test results are known there is a difference in sexual function between women after Caesarean section indication of second stage dystocia and elective $p = 0,003$ ($p \leq 0,05$). There is a difference between a woman's sexual function after childbirth Caesarean section on indications second stage dystocia and elective.

Keywords: *Caesarean section, second stage dystocia, elective, sexual function*

INTRODUCTION

Sexual health according to the World Health Organization (WHO), is a state of physical, emotional, mental and social well-being stable with regard to sexuality, and not merely the absence of disease, dysfunction, or weakness.¹

Sexuality is an important and integrated part in every woman's life. Sexual activity is included in the interpersonal relationships of each pair with each bringing a distinctive attitude, mutual need and give respon.²

Women at the age of late 30 years old or early 40 years old where sexual response reaches its peak, becoming more aware of the needs of his sexuality. Most women learn and deepen their knowledge of sex is a process for her lif.³

Women find it difficult to talk with her doctor about matters relating to sexual, and many doctors do not feel comfortable

discussing sexual issues with patients. The survey results obtained, 71% of adults believe that doctors will avoid things related to sexual problems that they come forward, and 68% say that they are afraid that the discussion about sexuality would cause embarrassment to their doctor. Surveys of physicians primary health services revealed that less than half of the doctors who ask life and concern sexual in patients new to them, and many doctors are doing assumptions that are less precise about the sexual activity of his patients based on marital status, profession, age, race, or social economic status.⁴

Disturbances in sexual activity, it can cause sexual dysfunction. Concern about sexuality and sexual dysfunction began to become commonplace in society. The survey found that nearly two thirds of women have concern for their sexuality. One third of women who are less interested

in sex, 20% said that sex is not always enjoy it.⁴

Research on sexuality began in the 1950s when Masters and Johnson describe the anatomy and physiology of the human sexual response. Sexual health after giving birth to a new study that was quite interesting. Pregnancy and transition to a state of parenthood, as well as other factors, greatly affect the sexuality of post labor.⁵

Childbirth itself is a physiological process that is experienced by women. In this process a series of major changes that occur in the mother to give birth to her fetus through the birth canal. The purpose of the management of labor is to encourage a safe birth for mothers and babies. Maternity should be recognized as a normal physiological process that most women experience it without complications. Puerperal period began after parturition is complete, and ended after approximately 6 weeks. However, all new genital apparatus recovered as before pregnancy within 3 months.⁶

Peschers et al evaluated the function of levator ani muscles before and after childbirth, and found that muscle strength was significantly reduced for 3 to 8 days postpartum after vaginal delivery, but not on post cesarean section, and returned to normal within 2 months at the most maternal postpartum.⁷

The most common sexual dysfunction was found in postpartum is dyspareunia. Perineal pain occurs in 42% of women immediately after delivery and significantly decreased by 20% and 10% at 8 and 12 weeks postpartum. Signorello et al, gain at 6 months postpartum primiparous about a quarter of women reported a decline in sensation, satisfaction, and the ability to reach orgasm than before delivery. At 3 and 6 months of 41% and 22% reported having dyspareunia.⁸

Urinary incontinence and genital prolapse or Alvi and considered to be the sequelae that can not be avoided due to the process of vaginal delivery. One in three women will experience incontinence during

his life by up to 65% will occur that starts during pregnancy or after childbirth. Clinical and epidemiological studies indicate that women who experience vaginal delivery have a higher risk for incontinence compared nullipara and women who undergo surgery Caesarean section. This risk is likely associated with the occurrence of pelvic floor damage due to the process of vaginal delivery difficult. It is estimated that the first vaginal delivery is the beginning of the base pelvic damage.⁹

This finding is supported by studies showing an association between vaginal delivery with mechanical and neurological damage in the pelvic floor where it is associated with the occurrence of urinary incontinence or Alvi or both. And also women who have a tendency of the trauma, pelvic floor and the occurrence of incontinence and pelvic organ prolapse caused by the weakness of previously existed because of the condition of collagen in the fascia pelvic basic.⁹

Pelvic floor muscles are directly responsible for the many sensations felt by a woman during sexual intercourse, and the strong grip of vagina felt by her partner.

Consensus Development Conference on Female Sexual Dysfunction, explaining aspects of sexual function are divided into four categories, namely: pain, desire, arousal, and orgasm disorders. Sexual pain disorders are the most common category that affects women in the postpartum period. Perineal pain and dyspareunia is postpartum problems that often occur and interfere with normal sexual function, which is usually the result of trauma to the perineum, episiotomy, and labor instrumentation.²

Sexual function in women can be measured with some kind of instrument self-report assessment, which are Golombok-Rust Inventory of Sexual Satisfaction (Griss), Brief Index of Sexual Functioning for women, Derogatis Interview for Sexual Functioning, Female Sexual Function Index (FSFI), and Sexual Function Questionnaire (SFQ).¹¹

Female Sexual Function Index (FSFI) developed a valid and accurate measurement on sexual function in women. The FSFI is a questionnaire that has been developed as an instrument that can be used for personal (self-report instrument) multidimensional to assess the existence of a sexual dysfunction in women. FSFI formulated to assess all aspects of female sexual function, including sexual desire, sexual arousal, lubrication, orgasm, satisfaction, and pain.¹²

Measures cesarean section provides the least exposure to the pelvic floor muscles from mechanical damage, and thus can protect in terms of sexual function. Compared with vaginal delivery, it seems logical to assume that women who give birth through caesarean section would be less likely to experience dyspareunia, since the risk of assisted delivery with episiotomy or abolished.⁴

METHOD

This study is observational analytic with cross sectional design using comparative in M. Djamil General Hospital and Networking Hospital. Obtained samples are 26 women after childbirth cesarean section for second stage dystocia and 26 women after elective Caesarean section were spawned from term pregnancies that meet the inclusion and exclusion criteria. Data analysis was performed using univariate and bivariate using independent T test.

RESULT AND DISCUSSION

The results of the study can be seen by the presentation of the following the difference between a woman's sexual function after childbirth with Caesarean section on indications second stage dystocia and elective can be seen in table 1 :

Table 1. The Domain Difference Between A Woman's Sexual Function After Childbirth With Caesarean Section On Indications Second Stage Dystocia And Elective

Domain	Group	n	Mean±SD	p value
Desire	2 nd Stage Dystosia	26	4,36 ± 1,26	0,006
	Caesarean section of Elective	26	5,19 ± 0,73	
Arousal	2 nd Stage Dystosia	26	4,54 ± 1,62	0,043
	Caesarean section of Elective	26	5,26 ± 0,61	
Lubrication	2 nd Stage Dystosia	26	5,03 ± 1,46	0,016
	Caesarean section of Elective	26	5,81 ± 0,55	
Orgasm	2 nd Stage Dystosia	26	4,73 ± 1,71	0,006
	Caesarean section of Elective	26	5,78 ± 0,56	
Satisfaction	2 nd Stage Dystosia	26	4,60 ± 1,62	0,004
	Caesarean section of Elective	26	5,67 ± 0,64	
Pain	2 nd Stage Dystosia	26	4,39 ± 1,72	0,000
	Caesarean section of Elective	26	5,84 ± 0,55	

Table 1 that the average female sexual function after cesarean section indication of second stage dystocia by domain of desire is 4,36 ± 1,26 and female sexual function after elective Caesarean section indication based on the domain of desire is 5,19 ± 0,73. Statistical test results are known there is a difference in sexual function between women after Caesarean section indication of second stage dystocia and elective indications based domain desire p = 0,006 (p ≤ 0,05).

Average female sexual function after cesarean section indication of second stage dystocia based domain arousal is 4,54 ± 1,62 and female sexual function after elective Caesarean section indication based domain arousal is 5,26 ± 0,61. Statistical test results are known there is a difference

in sexual function between women after Caesarean section indication of second stage dystocia and elective indications arousal based domain $p = 0,043$ ($p \leq 0,05$).

Average female sexual function after cesarean section indication of second stage dystocia based domain lubrication is $5,03 \pm 1,46$ and female sexual function after elective Caesarean section indication based domain lubrication is $5,81 \pm 0,55$. Statistical test results are known there is a difference in sexual function between women after Caesarean section indication of second stage dystocia and elective indications based lubrication domain $p = 0,016$ ($p \leq 0,05$).

Average female sexual function after cesarean section indication of second stage dystocia based domain orgasm is $4,73 \pm 1,71$ and female sexual function after elective Caesarean section indication based domain orgasm is $5,78 \pm 0,56$. Statistical test results are known there is a difference in sexual function between women after Caesarean section indication of second stage dystocia and elective indications based domain orgasm $p = 0,006$ ($p \leq 0,05$).

Average female sexual function after cesarean section indication of second stage dystocia based domain satisfaction are $4,60 \pm 1,62$ and female sexual function after elective Caesarean section indication satisfaction based domain that is $5,67 \pm 0,64$. Statistical test results are known there is a difference in sexual function between women after Caesarean section indication of second stage dystocia and elective indications satisfaction based domain $p = 0,004$ ($p \leq 0,05$).

Average female sexual function after cesarean section indication of second stage dystocia based domain pain that is $4,39 \pm 1,72$ and female sexual function after elective Caesarean section based domain pain indication is $5,84 \pm 0,55$. Statistical test results are known there is a difference in sexual function between women after Caesarean section indication of second stage dystocia and elective indications based domain pain $p = 0,000$ ($p \leq 0,05$)

Table 2. The Difference Between A Woman's Sexual Function After Childbirth With Caesarean Section On Indications Second Stage Dystocia And Elective

Sexual Function	n	Mean±SD	p value
Second Stage Dystocia	26	27,70±8,53	0,003
Elective Caesarean Section	26	33,55±3,18	

Table 2 known the average female sexual function after cesarean section indication of second stage dystocia is $27,70 \pm 8,53$ and female sexual function after elective Caesarean section indications are $33,55 \pm 3,18$. Statistical test results are known there is a difference in sexual function between women after Caesarean section indication of second stage dystocia and elective $p = 0,003$ ($p \leq 0,05$).

Table 3. The Associated Between A Woman's Sexual Function After Childbirth With Caesarean Section On Indications Second Stage Dystocia And Elective

Sexual Function n	Sexual Satisfaction				Total		p value
	Bad		Good		f	%	
	f	%	f	%			
2 nd Stage Dystosia	9	34,6	16	65,4	26	100	0,04
Elective Caesa rean Section	2	7,7	24	92,3	26	100	
Amount	11	21,2	40	78,8	52	100	

Table 3 shows that sexual satisfaction was higher in women after cesarean section with an indication of dystocia second stage is 9 respondents (34,6%) compared with elective indication is 2 respondents (7,7%). Based on the test results there is a relationship statistic sexual function between women after

Caesarean section indication of second stage dystocia and indication of elective with $p = 0,042$ ($p \text{ value} \leq 0,05$).

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The results of this research similar with research conducted by Darmayasa (2013) which states that there are differences in sexual function after vaginal delivery with episiotomy and cesarean section with a $p \text{ value} = 0,030$ ($p \text{ value} < 0,05$).¹³ The results Khajehei et al, do a study of 40 primiparas 6-12 months after vaginal delivery and cesarean section. They get sexual dysfunction is the most common found in the group of vaginal delivery are decreased libido (80%), dissatisfaction (65%), loose vagina (55%), whereas in the group cesarean section issues common is vaginal dryness (85%), dissatisfaction (61%), and decreased libido (35%). Found significant differences clinical.¹⁴

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Sexual activity is included in the interpersonal relationships of each pair with each bringing a distinctive attitude, mutual need and give respon.²

Based on the Consensus Development Conference on Female Sexual Dysfunction, aspects of sexual function are divided into four categories, namely: pain, desire, arousal, and orgasm disorders. Sexual pain disorders are the most common category that affects women in the postpartum period. Perineal pain and dyspareunia is common postpartum problems and interfere with normal sexual function, which is usually the result of trauma to the perineum, episiotomy, and labor instrumentation.²

Sexual function in women can be measured with some kind of instrument self-report assessment, which are Golombok-Rust Inventory of Sexual Satisfaction (Griss), Brief Index of Sexual Functioning for women, Derogatis Interview for Sexual Functioning, Female Sexual Function Index (FSFI), and Sexual Function Questionnaire (SFQ). Female Sexual Function Index (FSFI) developed a valid and accurate measurement on sexual function in women.¹¹

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Cesarean section is not without danger, even to sexuality itself. The main complications of cesarean section deliveries is damage to organs such as the bladder and uterus During the operation conduct.⁴

Pregnancy and childbirth result in pelvic floor mothers are particularly vulnerable to damage. One of the factors which resulted in damage to the pelvic floor is the mechanical strain on the pelvic floor

as a result of an increase in the size of the head of newborns through the birth.¹⁵

The second stage of labor, the pressure arising between the fetal head by vaginal wall by an average of 100 mmHg and may even reach 230 mmHg. If it happens in a longer time course will result in changes to the physical and functional nature permanent.¹⁶

Labor resulted in pressure with increasing intensity even reach three times in the mother's pelvis. So it is not surprising if it happens in a few hours can often result in physical sequelae of both the connective tissue, muscles, nerves, and organs in the pelvis. Pudendal nerve supplies the majority of anatomical structures that support the pelvis, covering perineum, vagina, levator muscle complex, urethra sphincter, and anus.¹⁶

Compression and stretching of the pudendal nerve during childbirth seems to be an important risk factor causes a decrease in the levator muscle function. Stretching and compression of the pudendal nerve often occurs when the fetus down through the spine ischiadika the middle door midpelvis or pelvis. As a result of these neuropathic changes, among others, a failure occurs contraction of the levator complex, such as muscle pubokoxigeus and failure to increase sphincter pressure during coughing or sneezing and decreased or even lost when the rest of the complex tone and body levator perineum.¹⁶

Snooks and Swash reported that the pudendal nerve damage is reversible common in vaginal delivery, the effect seems to be prevented by cesarean section childbirth. Nerve damage is increasing in many cases with the forceps delivery, multiparity, the elongation of the second stage of labor, the degree perineal tears three or four, and macrosomia. Loss of the pudendal nerve innervation to the muscle pubococcygeus and anal sphincter muscles accompanies almost 42 to 80% of vaginal deliveries, although some reinnervation by surrounding nerves can occur, but the loss

of muscle function permanently often happened.¹⁶

Pudendal nerve damage resulted in the pudendal nerve conduction disorders and inervasinya in various organs in the pelvis after birth, so that the nerve damage often associated with the incidence of pelvic organ prolapse and urinary incontinence and sexual problems after delivery. Snooks study concluded that the pattern of the pudendal nerve damage during birth increases the risk of urinary and faecal incontinence demonstrated by using the tool electromiography.¹⁷

The main complications of cesarean section deliveries is damage to organs such as the bladder and uterus During the conduct of operations, anesthetic complications, hemorrhage, infection, and thromboembolism. Maternal mortality is greater in cesarean section deliveries than vaginal deliveries. It is difficult to ascertain whether this happens because the operating procedures or because the reasons that cause pregnant mothers should surgery.¹⁸

Based on our analysis in accordance with the results of this research study Baksu, et al. (2007), who reported there is a significant reduction in the FSFI total score for all key dimensions of sexual function (desire, arousal, lubrication, orgasm, satisfaction, and pain), between the conditions before pregnancy and six months post episiotomy mediolateralis.¹⁹

Emotional and physical problems after childbirth is a common problem and is likely to increase over time. Complaints such as fecal incontinence can be increased uri and medically, but the emotional health problems apparently not recognized. It is quite possible that sexual disharmony is a major contributor to the happiness of women and their partners. Given the frequency of sexual health issues and postpartum sexual morbidity, it's only natural to have to pay more attention to the use of cesarean section for distosi the second stage. Results of research is essential in counseling women during the antenatal period on the way of delivery and

related issues in terms of sexual function. Postpartum sexual counseling should be part of the follow-up antenatal, despite the obstacles encountered so far in the routine control of six weeks postpartum postpartum most women do not start their sexual activity, so that the problem of sexual dysfunction tends to be ignored. Other than that needed to do Kegel exercises regularly by practicing gymnastics activity three times a day so that the movement of the Kegel exercises can help to tighten the pelvic muscles under severe postpartum one indication of dystocia cesarean section after the second stage. This activity is helpful tighten the muscles under the uterus, bladder, and colon that can help in improving sexual satisfaction.

CONCLUSION

The average female sexual function after cesarean section indication of second stage dystocia is $27,70 \pm 8,53$ and female sexual function after elective Caesarean section indications are $33,55 \pm 3,18$. Statistical test results are known there is a difference in sexual function between women after Caesarean section indication of second stage dystocia and elective p = 0,003 ($p \leq 0,05$).

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