Training is a partnership between the trainer and the trainee. Therefore, the role of a trainer in PGME should not be ignored. The new changes will fail to deliver improvements unless the trainers involved in PGME have confidence and commitment towards the process. Trainers should see it as a constructive opportunity rather than an irrelevant chore. If the changes are to be properly implemented, there must be advantages for the trainers too. Training should not be considered merely as a benign altruistic charity.

The trainers, especially the surgical ones, are under pressure from the two sides—providing service and training. When a trainer is taking a trainee through a procedure, it will almost always take much longer and the service suffers. While laudable and fairly successful attempts are made by surgical trainers to maintain a fair balance between service and training, further increases in commitment on training may make this adjustment increasingly hard to tolerate.

Teaching units with no access to computers, new books, journals and the internet are not appropriate teaching environments. Most of the trainers of the Department of Health do not have office space or secretarial assistance.

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Postgraduate trainers have increasingly come to believe that their commitment is taken for granted. Hence, they need to be properly rewarded. This is essential if the postgraduate training is to prosper.

For this certain obstacles must be cleared. Funds should be allocated specifically for training time and supporting training programmes. At the moment this occurs on the cheap, and training largely occurs through the goodwill of the trainers. The PGIM and the Department of Health should acknowledge the educational significance and importance of the trainers. They should receive appropriate recognition and support. For a start, each year one or two good trainers from every speciality can be selected and rewarded with an infrastructure necessary for a good training environment.

This proposal may raise more problems than it solves. Nevertheless, it will at least stimulate a dialogue on the importance of the trainers and on innovative educational initiatives in PGME.

References

Correspondence

To the Editors:

Couple characteristics and outcome of therapy in vaginismus

In the article titled, ‘Couple characteristics and outcome of therapy in vaginismus’ [1], Munasinghe and colleagues appear to have confused dyspareunia with vaginismus. Vaginismus is a classical psychosomatic disorder which usually results in complete apareunia and non-consummation of marriage. Milder forms of vaginismus can cause dyspareunia at coitarche and it may sometimes persist thereafter. Their reference to Rafi [2] with regard to avoidable causes of secondary vaginismus is incorrect. Rafi reported a case of bilateral vaginal tears occurring when an inexperienced person inserted a Cusco’s bivalve vaginal speculum into a sexually active nulliparous woman with vaginismus.

Vulvo-vaginal trauma results in scarring, and usually leads to secondary dyspareunia, but it may rarely lead to subsequent vaginismus due to fear of recurrence of the injury. Infection on the other hand causes dyspareunia, and when it is treated it should not lead to vaginismus. Vulvo-vaginal infection and trauma, as well as developmental abnormalities, pelvic inflammatory disease, pelvic endometriosis and atrophy of the vaginal epithelium cause dyspareunia. Antibiotics, surgery, vaginal dilatation, local analgesics and hormones are all accepted forms of therapy depending on the cause of dyspareunia. Before embarking on treatment in a woman having coital difficulties, it is essential to differentiate between vaginismus and other causes of dyspareunia by obtaining a detailed history and carrying out a complete gynaecological examination.

The therapy of vaginismus described by Munasinghe and colleagues is the method of gradual vaginal desensitisation, which is extremely laborious, time consuming and not quite satisfactory (80% success reported by them). The alternative is—the rapid vaginal desensitisation method [3]. This method involves insertion of a mould or large dilator into the vagina. No surgery is involved and the principle is simple desensitisation and not physical dilatation of the vagina. This method is easy, quick and rarely fails. However, it needs hospitalisation and a short general anesthetic. For this method to succeed, privacy and the presence of partner is essential for a minimum of 24 hours after the procedure. Therefore it is difficult to be carried out in a busy ward of a government hospital. The author has used this method with success in more than 60 patients during the last 17 years.
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References


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To the Editors:

In reply:

Couple characteristics and outcome of therapy in vaginismus [1]

Professor Goonewardene’s contention in his letter (pages 148–149) that we “appear to have confused dyspareunia with vaginismus” is without foundation in fact. We have clearly defined vaginismus in our article as “a psychosomatic disorder,” and our management involved no drugs or an operation under general anaesthesia. [1]. He may have been misled to believe that we were confused on this matter by our sentence, “Avoidable causes of secondary vaginismus include vaginal trauma, infection or surgery as in poor obstetric practices at delivery” [1].

Regarding vaginismus occurring secondary to organic causes we are on solid ground. Here are a few relevant excerpts.

1. “On occasion, therefore, it (vaginismus) may be secondary to organic disease” [2].

2. “Secondary vaginismus cases may be the result of unpleasant experiences or trauma” [3].

3. Vaginismus, like other disturbances of sexual functioning may be described as primary or secondary, and as situational or complete …” [4]. In this article too, “vaginitis and other organic factors” are causally linked to secondary vaginismus.

Goonawardene describes in his letter our management of vaginismus as “extremely laborious and time consuming and not very satisfactory (80% success as reported by them)” [5]. In our series, neither the therapists nor the couples found the management “laborious”, for hardly any labour was involved. As for the time spent, a given couple expended at most 2 h for 4 or 5 interactions of 15–30 min each. All treatments for vaginismus have distinct failure rates, and our experience [1] of the various methods used by others (Table 1) is no different from that of reported series. To a large extent success rates depend on duration and quality of follow up. And failures tend to end up with another therapist, and are not often counted as failures by the initial therapist.

Goonawardene says that the technique he uses for the treatment of this psychosomatic disorder is to insert a “mould or a large dilator into the vagina” under a general anaesthetic, when both the psyche and the soma are unconscious. The insertion may take only a couple of minutes of the operator’s time, which is valuable in every sense of that word. But what about the couples’ time? The hapless spouse has to hang about for a minimum of 24 h [5], making a minimum total of 48 man/woman hours of their time, which is presumably of little value. In addition, the couple has to spend for a stay in a private hospital (for males cannot stay in government hospital female wards), plus theatre charges and fees for the operator and the anaesthetist.

Above all, general anaesthesia of itself carries small but definite risks of mortality and morbidity even in elective minor operations. Every couple has a legally recognised right to be told of this risk, however small it might be, before obtaining consent for the procedure described [5].

References


