

Endometriosis-Related Sexual Pain

Causes, Deep Dyspareunia, Diagnosis, Treatment, Fertility Impact and an Integrative Unani Approach

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Introduction

When a woman tells me, **“Doctor, intercourse has become painful, especially with deep penetration, and the pain becomes worse around my periods,”** endometriosis is one of the important conditions that needs to be considered.

Endometriosis-related sexual pain is not simply “pain during sex.” It can become a complex problem involving the pelvic organs, nerves, pelvic-floor muscles, sexual response, emotional health, relationship intimacy and sometimes fertility.

Endometriosis affects an estimated **10% of women of reproductive age—around 190 million worldwide**. The World Health Organization recognizes painful intercourse as one of the important manifestations of endometriosis and notes that the condition can substantially affect sexual health, fertility, mental well-being and quality of life.

In my clinical approach, I consider it particularly important to tell patients that **sexual pain should not be normalized simply because a woman has endometriosis**.

Similarly, a woman should not be told to tolerate painful intercourse because she is married or trying to become pregnant.

Pain is giving us information.

Our job is to understand **where the pain is coming from, why it persists, which structures are involved and how it can be treated without ignoring the woman's reproductive and sexual-health goals**.



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What Is Endometriosis?

Endometriosis is a chronic condition in which tissue resembling the lining of the uterus grows outside the uterus.

Endometriosis may involve the:

- Ovaries
- Pelvic peritoneum
- Fallopian-tube region
- Outer surface of the uterus
- Uterosacral ligaments
- Area behind the uterus
- Rectovaginal region
- Bowel
- Bladder
- Ureters
- Vagina
- Other pelvic structures

Less commonly, endometriosis can occur outside the pelvis.

These lesions can be associated with inflammation, fibrosis, scar formation and adhesions. Depending on their location and the individual's pain response, they may cause period pain, chronic pelvic pain, pain during bowel movements, urinary symptoms, infertility and pain during or after sexual intercourse.

The World Health Organization emphasizes that there is currently **no treatment that definitively cures endometriosis**, although symptoms can often be substantially controlled with medicines, surgery and multidisciplinary care.

What Is Endometriosis-Related Sexual Pain?

Endometriosis-related sexual pain generally refers to pain associated with sexual activity in a woman who has suspected or confirmed endometriosis.

The medical term most often used is **dyspareunia**.

Endometriosis is particularly associated with **deep dyspareunia**, meaning pain felt deeper in the pelvis during deep vaginal penetration rather than pain only at the vaginal entrance. NICE specifically lists **deep pain during or after sexual intercourse** among symptoms that should raise suspicion for endometriosis.

However, not every woman with endometriosis experiences exactly the same type of sexual pain.

A patient may describe:

- Deep pelvic pain during penetration
- Pain when certain positions are used
- Pain immediately after intercourse
- Pelvic aching for hours after sex
- Cramping during orgasm
- Superficial burning at the vaginal opening
- Pelvic-floor tightening
- Rectal pressure during penetration
- Bladder discomfort with intercourse
- Pain around ovulation or menstruation
- Fear of penetration because previous intercourse was painful

This variation is clinically important because **not all sexual pain in a woman with endometriosis is necessarily caused directly by endometriosis lesions.**

Deep Dyspareunia Versus Superficial Dyspareunia

Understanding where the pain occurs helps guide diagnosis.

Deep Dyspareunia

Deep dyspareunia means pain felt deeper inside the pelvis during or after deep penetration.

The woman may describe:

“It feels as though something is being hit deep inside.”

or:

“Certain positions cause a sharp pain behind the uterus.”



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or:

“The pain becomes severe when penetration is deeper.”

Deep sexual pain is particularly relevant to endometriosis.

Superficial Dyspareunia

Superficial or introital dyspareunia is pain mainly at or near the vaginal opening.

It can occur because of conditions such as:

- Vestibulodynia
- Vulvodynia
- Vaginal infection
- Dermatological disease
- Vaginal dryness
- Hormonal deficiency
- Pelvic-floor hypertonicity
- Scar tissue
- Genitourinary syndrome of menopause

ACOG emphasizes that painful intercourse can arise from pain at the vulva, vaginal entrance or deeper pelvic structures and that endometriosis is only one of several possible causes.

A woman with endometriosis may have **both superficial and deep pain simultaneously**, particularly when chronic pelvic pain has produced secondary pelvic-floor dysfunction.

Why Does Endometriosis Cause Pain During Sex?

Endometriosis-related sexual pain is rarely explained by one mechanism.

Modern research increasingly supports a **multifactorial model** involving lesions, inflammation, scar tissue, nerves, pelvic-floor muscles and altered processing of pain by the nervous system.

This explains why two women with apparently similar endometriosis may experience very different levels of sexual pain.



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1. Deep Endometriosis in Sensitive Pelvic Areas

Deep pelvic endometriosis can involve structures that are mechanically stressed during intercourse.

Important sites include:

- Uterosacral ligaments
- Retrocervical region
- Rectovaginal septum
- Posterior vaginal region
- Rectum or bowel
- Bladder
- Other posterior pelvic structures

Deep endometriosis is recognized particularly in the uterosacral and rectovaginal regions and may contribute to deep dyspareunia.

During deep penetration, movement of the vagina, cervix and uterus can place pressure on these painful structures.

This may reproduce the characteristic deep pelvic pain.

2. Inflammation

Endometriosis is associated with local inflammatory activity.

Inflammatory mediators can affect surrounding tissues and activate pain pathways.

Research into endometriosis-associated chronic pain describes abnormal inflammatory signaling, cytokines, nerve-growth factors and altered nerve-fiber activity as possible contributors to persistent pain.

This helps explain why pain is not determined solely by how large a lesion looks on imaging or during surgery.

A small lesion may sometimes produce substantial pain, while another patient with extensive disease may report comparatively little pain.

3. Adhesions and Restricted Pelvic Movement

Endometriosis can lead to fibrosis and adhesions.



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Adhesions are bands of scar tissue that can cause pelvic organs to become less mobile or adhere to nearby structures.

Normal sexual intercourse involves movement of the vagina, cervix, uterus and surrounding pelvic tissues.

If these structures have become fixed or tender because of adhesions, deeper penetration may become painful. ACOG notes that endometriosis-associated inflammation and bleeding can produce scar tissue and adhesions.

4. Pelvic-Floor Muscle Tightness

The pelvic-floor muscles are extremely important in sexual function.

If intercourse repeatedly causes pain, the body may begin protecting itself automatically.

The pelvic-floor muscles tighten before or during penetration.

Initially this may be a protective response.

Over time, however, the muscles can remain excessively tense and develop tenderness or trigger points.

Then another cycle begins:

endometriosis pain → fear of pain → pelvic-floor tightening → more painful penetration → greater fear → greater muscle guarding.

Research in women with surgically confirmed endometriosis has found that pelvic-floor tenderness is associated with greater severity of deep dyspareunia independently of endometriosis stage.

Therefore, removing an endometriosis lesion alone does not necessarily resolve every woman's sexual pain.

5. Peripheral Sensitization

Repeated inflammation and painful stimulation can make local nerves more sensitive.

This is called **peripheral sensitization**.

A stimulus that previously caused little discomfort can gradually become significantly painful.

Endometriosis-associated pain research identifies altered peripheral nerve signaling as one of the mechanisms involved in chronic pelvic pain.



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6. Central Sensitization

Pain is ultimately processed by the brain and spinal cord.

When pain continues for months or years, the nervous system can sometimes become increasingly responsive to painful input.

This is called **central sensitization**.

The important point for patients is that central sensitization does **not** mean the pain is imaginary.

It means the nervous system itself has become more efficient at generating and amplifying pain.

A 2025 systematic review found that women with features of central sensitization tended to have less improvement and more persistent pain after endometriosis surgery, demonstrating why some patients continue experiencing pain despite technically successful treatment of lesions.

This is one of the most important developments in our modern understanding of endometriosis-associated pain.

7. Bladder Pain and Other Associated Conditions

Some women with endometriosis also experience:

- Bladder pain syndrome
- Irritable bowel symptoms
- Vulvodynia
- Vestibulodynia
- Pelvic-floor myofascial pain

These conditions can contribute independently to sexual pain.

An important study of women with surgically confirmed endometriosis found associations between severe deep dyspareunia and both pelvic-floor tenderness and painful bladder syndrome, even after taking endometriosis severity into account.

Therefore, if a woman continues experiencing pain after endometriosis treatment, the correct question is not automatically:

“Has the endometriosis come back?”



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We should also ask whether muscles, bladder function, vulvar pain or sensitization are contributing.

8. Psychological and Relationship Consequences

Endometriosis begins as a physical disease, but persistent sexual pain naturally affects the mind and relationship.

Imagine a woman who expects pain every time her partner initiates intercourse.

She begins thinking:

“It is going to hurt again.”

The body becomes tense.

Arousal falls.

Lubrication may decrease.

Pelvic-floor muscles contract.

Penetration becomes more painful.

After repeated experiences like this, desire may decline because sexual activity has become associated with pain rather than pleasure.

This does not mean the pain is psychological.

It means **biological pain has created psychological and sexual consequences**, which can then further influence the biological pain response.

Reviews of endometriosis-related sexual pain therefore recommend a biopsychosocial and multidisciplinary approach rather than viewing the problem only as pelvic lesions.

How Endometriosis Affects Overall Sexual Function

Endometriosis can affect much more than the pain component of sex.

A systematic review and meta-analysis found that women with endometriosis had a higher likelihood of sexual dysfunction than women without endometriosis and had lower scores across multiple domains, including:

- Desire
- Arousal
- Lubrication



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- Orgasm
- Satisfaction
- Pain

The pooled analysis found an odds ratio of approximately **1.71 for sexual dysfunction** among women with endometriosis compared with controls.

This demonstrates why sexual health should be discussed as part of endometriosis care rather than treating it as a secondary or embarrassing issue.

Pain During Orgasm

Some women report pain not only during penetration but also during orgasm.

Orgasm involves rhythmic contractions of pelvic-floor muscles and the reproductive tract.

If pelvic tissues are inflamed, adhesed, hypersensitive or associated with pelvic-floor spasm, these contractions may provoke pain.

Pain during orgasm should therefore be discussed during clinical assessment rather than assuming that endometriosis-related sexual pain occurs only at penetration.

Does the Severity of Endometriosis Predict Sexual Pain?

Not reliably.

One of the most clinically important lessons in endometriosis is that **the amount of visible disease does not always correspond directly to the amount of pain.**

A woman with relatively limited visible endometriosis can experience severe sexual pain.

Another woman with extensive disease may have less pain.

This occurs because pain depends on location, nerve involvement, adhesions, pelvic-floor function, comorbid pain disorders and nervous-system sensitization, not simply lesion burden.

Therefore, I do not believe that a patient's pain should ever be dismissed because imaging appears “mild.”

When Should Endometriosis Be Suspected?



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According to the updated NICE guidance, endometriosis should be considered when a woman presents with one or more of the following:

- Chronic pelvic pain
- Significant menstrual pain
- Deep pain during or after intercourse
- Cyclical painful bowel movements
- Cyclical urinary symptoms
- Infertility accompanied by suggestive symptoms

A family history in a first-degree relative also increases the likelihood.

The combination of **severe period pain plus deep dyspareunia** deserves particular attention.

Questions I Ask About Sexual Pain

When evaluating a patient, I do not simply ask:

“Does intercourse hurt?”

I want to understand the pattern.

Important questions include:

- Where exactly is the pain?
- Does pain occur at initial penetration or deeper inside?
- Does it happen in every position?
- Is it worse around menstruation?
- Does the pain persist after sex?
- Is orgasm painful?
- Is there bowel pain during periods?
- Is there urinary pain?
- Is tampon insertion painful?
- Is pelvic pain present outside sexual activity?
- Does she have painful periods?
- Has intercourse become progressively more difficult?



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- Does she tighten involuntarily before penetration?
- Has sexual desire fallen because of anticipated pain?
- Is the couple trying to conceive?

This information can help distinguish **lesion-related deep pain from vestibular pain, pelvic-floor dysfunction or a combination of several factors.**

Diagnosis of Endometriosis-Related Sexual Pain

There is no single laboratory test that explains sexual pain.

Assessment typically combines:

- Detailed history
- Pelvic examination where appropriate and consented to
- Pelvic-floor assessment
- Imaging
- Consideration of associated bladder, bowel and vulvar conditions
- Evaluation of fertility when relevant

A normal examination does not exclude endometriosis.

Pelvic Examination

A pelvic examination may reveal:

- Pelvic tenderness
- Reduced uterine mobility
- Tenderness behind the cervix
- Nodularity in the posterior vaginal fornix
- Pelvic-floor tenderness
- Adnexal enlargement
- Pain reproduced by palpation

NICE recommends pelvic examination in suspected endometriosis, while recognizing that abdominal examination can be used when internal examination is declined or inappropriate.



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The examination should always be performed gently and with consent.

A woman with severe sexual pain should never feel that she must tolerate a painful examination simply to prove that her symptoms are genuine.

Transvaginal Ultrasound

One of the important changes in more recent diagnostic guidance is greater use of imaging earlier in assessment.

NICE's updated 2024 recommendations advise **transvaginal ultrasound for people with suspected endometriosis even when pelvic examination is normal.**

Ultrasound can help identify:

- Ovarian endometriomas
- Deep endometriosis
- Bowel involvement
- Bladder involvement
- Ureteric disease
- Other pelvic pathology

However, another crucial message is:

A normal ultrasound does not exclude endometriosis.

NICE explicitly advises clinicians not to rule out endometriosis merely because examination and ultrasound are normal.

MRI

Specialist pelvic MRI can be helpful when deep endometriosis is suspected or when the extent of disease needs to be mapped before treatment.

NICE recommends considering specialist transvaginal ultrasound or pelvic MRI when evaluating deep endometriosis and emphasizes that these examinations should ideally be planned and interpreted by clinicians experienced in gynecological imaging.

MRI can be especially valuable when bowel, bladder, rectovaginal or complex posterior-compartment disease is suspected.



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Does Every Woman Need Laparoscopy?

No.

Modern practice has moved away from requiring immediate diagnostic surgery for every suspected case.

Clinical assessment and imaging can often support treatment decisions without surgery first.

However, laparoscopy may still be considered when symptoms strongly suggest endometriosis despite normal imaging, when treatment has failed, when deep disease needs treatment, or when surgery is otherwise clinically appropriate.

NICE states that diagnostic laparoscopy can still be considered even when ultrasound or MRI is normal if clinical suspicion remains.

The 2022 ESHRE guideline similarly represented an important change from older approaches by reducing reliance on diagnostic laparoscopy as the automatic first requirement for diagnosis.

Should CA-125 Be Used to Diagnose Endometriosis?

No.

CA-125 may sometimes be abnormal in endometriosis, but it is not sufficiently accurate for diagnosis.

NICE specifically recommends **not using serum CA-125 to diagnose endometriosis**.

Treatment of Endometriosis-Related Sexual Pain

Treatment should be personalized.

The ideal plan depends on:

- Pain severity
- Location of disease
- Deep versus superficial pain
- Pelvic-floor involvement
- Age
- Previous treatments



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- Fertility goals
- Contraceptive requirements
- Associated bladder or bowel symptoms
- Previous surgery
- Patient preferences

The objective is not merely to make intercourse possible.

The objective is to **reduce pain, improve sexual function and quality of life, protect fertility where important and reduce the chance that chronic pain mechanisms become increasingly established.**

Pain-Relieving Medicines

For endometriosis-associated pain, medications such as NSAIDs may be considered.

NICE recommends discussing risks and benefits and suggests a short trial of paracetamol or an NSAID for first-line pain management. If pain remains inadequately controlled, further assessment and alternative pain management should be considered.

Painkillers may help symptoms but do not remove endometriosis lesions.

Hormonal Treatment

Hormonal suppression is a major component of endometriosis pain management when pregnancy is not currently being attempted.

Options can include:

- Combined hormonal contraceptives
- Progestogens
- GnRH agonists
- GnRH antagonists
- Selected other hormonal treatments

The ESHRE guideline strongly recommends hormone treatment as one of the options for endometriosis-associated pain and specifically recommends combined hormonal contraceptives for reducing **endometriosis-associated dyspareunia**, dysmenorrhea and non-menstrual pain.



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Progestogens are also recommended options for endometriosis-associated pain.

Newer GnRH Antagonist Options

Treatment options continue to evolve.

In 2025, NICE added two oral GnRH-antagonist-based options in England for adults of reproductive age who have previously received medical or surgical treatment for endometriosis:

- **Relugolix–estradiol–norethisterone**
- **Linzagolix with hormonal add-back therapy**

These developments are important internationally, although **drug approval, availability, indications and cost differ between countries**, including India.

They should be considered specialist prescription treatments rather than self-treatment.

Hormonal Treatment and Pregnancy Planning

This is where management becomes particularly important for couples attending infertility care.

Hormonal treatment can reduce endometriosis pain, but most suppress ovulation or otherwise prevent conception during use.

Therefore, if a woman is **actively trying to become pregnant**, pain treatment and fertility planning need to be coordinated.

ESHRE advises against ovarian-suppression treatment solely to improve fertility, and NICE likewise separates pain management from fertility-oriented treatment.

In other words:

Hormonal suppression can be useful for pain, but it is not a fertility treatment.

Surgery for Endometriosis-Related Pain

Surgery can be an important treatment option in selected patients.

Laparoscopic surgery may involve:

- Excision of endometriosis lesions



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- Treatment of adhesions
- Management of ovarian endometriomas
- Treatment of deep endometriosis

ESHRE recommends surgery as one option for reducing endometriosis-associated pain and states that removal of deep endometriosis can be considered because it may improve pain and quality of life. Women with deep endometriosis should ideally be referred to a center with appropriate expertise.

This is particularly important when disease affects the bowel, bladder or ureters, where surgery can become complex.

Will Surgery Always Cure Sexual Pain?

No.

This is an extremely important point.

Surgery may substantially improve sexual pain when endometriosis lesions and adhesions are important drivers.

But sexual pain may persist if additional mechanisms are present, including:

- Pelvic-floor myofascial pain
- Bladder pain syndrome
- Vulvodynia
- Central sensitization
- Fear-related muscle guarding
- Other chronic pain conditions

A 2025 systematic review found that central sensitization was associated with a higher likelihood of persistent pain following treatment.

Therefore, persistent pain after surgery does not automatically mean that the surgery “failed” or that all lesions were necessarily missed.

Sometimes the pain system itself also requires treatment.

Pelvic-Floor Physiotherapy



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This is an increasingly important component of endometriosis-associated pain management.

A pelvic-floor physiotherapist can assess whether the muscles are:

- Excessively tense
- Painful
- Poorly coordinated
- Developing trigger points
- Contracting involuntarily with penetration

Treatment may involve:

- Relaxation training
- Manual techniques
- Myofascial treatment
- Breathing exercises
- Gradual desensitization
- Movement and posture work
- Individualized pelvic-floor exercises
- Education

Recent evidence is encouraging.

A 2025 systematic review and meta-analysis found that physiotherapy interventions reduced endometriosis-associated pain compared with non-physiotherapy approaches.

Another recent meta-analysis found improvements in dyspareunia, pelvic pain and quality-of-life outcomes with several physical-therapy approaches, although interventions were diverse.

At the same time, the newest systematic review specifically examining **sexual function** found only a trend toward improvement and concluded that evidence remains limited and inconclusive because available studies are small and heterogeneous.

So pelvic rehabilitation is promising and useful for appropriately selected patients, but it should not be advertised as a guaranteed cure for sexual dysfunction.



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Pelvic-Floor Treatment Is Not Simply “Do Kegel Exercises”

This distinction is important.

If a woman's pelvic floor is already excessively tight, repeatedly strengthening the muscles without proper assessment may worsen pain.

Some women need relaxation and release rather than additional strengthening.

Therefore, pelvic-floor treatment should ideally be individualized by a clinician trained in pelvic pain.

Sexual and Psychosexual Counselling

Sexual counselling can become extremely valuable when endometriosis has caused:

- Fear of penetration
- Sexual avoidance
- Reduced desire
- Reduced arousal
- Relationship conflict
- Loss of sexual confidence
- Anxiety about pregnancy
- Fear that intercourse will cause physical damage
- Difficulty communicating about comfortable positions

WHO specifically includes multidisciplinary pain management, physiotherapy and cognitive behavioral approaches among supportive interventions that can help patients with endometriosis-related pain and its emotional burden.

Sexual counselling does **not** imply that endometriosis is psychological.

It addresses the secondary consequences of living with recurrent sexual pain.

Should a Woman Continue Intercourse Despite Pain?

I generally advise against repeatedly forcing painful penetration.

Persistent painful intercourse can reinforce:

pain → anticipation → muscle guarding → more pain.



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ACOG recommends communication between partners and suggests sexual activities that do not cause pain when intercourse is painful.

Temporary modification of sexual activity is not failure.

Sometimes reducing painful penetration while the underlying problem is treated is an important part of recovery.

Lubricants

Adequate lubrication can reduce friction-related discomfort.

However, lubricant alone will not usually resolve true deep endometriosis-associated dyspareunia.

If the pain is coming from deep lesions, adhesions, pelvic-floor spasm or sensitization, lubricant can only address the friction component.

This distinction is important because patients sometimes continue trying increasingly different lubricants when the real problem is deep pelvic pain.

Choosing Sexual Positions

Women often discover that some sexual positions produce much more pain than others.

Positions allowing the woman greater control over the depth and speed of penetration may be better tolerated.

The aim should be comfortable sexual activity, not forcing a specific position.

Partner communication is extremely important.

Endometriosis-Related Sexual Pain and Infertility

Endometriosis can affect fertility independently of sexual pain.

WHO notes that endometriosis is common among women experiencing infertility, and inflammation, adhesions, ovarian involvement and altered pelvic anatomy may all contribute.

Sexual pain can create an additional reproductive difficulty.

If deep penetration becomes painful, couples may:

- Have intercourse less frequently



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- Avoid intercourse during the fertile window
- Experience performance pressure
- Develop sexual avoidance
- Lose spontaneity in their relationship

Therefore, sexual pain can become a **functional barrier to natural conception** even in addition to the biological effects of endometriosis.

When Pregnancy Is the Priority

Treatment planning changes significantly when the patient wants pregnancy now.

Hormonal suppression generally prevents conception during treatment.

Instead, the evaluation may need to consider:

- Age
- Duration of infertility
- Ovarian reserve
- Semen analysis of the male partner
- Tubal status
- Endometrioma
- Deep disease
- Previous surgery
- Severity of pain

NICE states that fertility-related endometriosis management should involve multidisciplinary input and appropriate fertility expertise.

For selected disease not involving the bowel, bladder or ureters, laparoscopic excision or ablation with adhesiolysis may improve the chance of spontaneous pregnancy.

However, ovarian surgery must be planned carefully because surgery for endometrioma can affect ovarian reserve.

Surgery Before IVF Is Not Automatically Required



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Another important modern principle is that surgery should not automatically be performed solely because IVF or another assisted reproductive treatment is planned.

ESHRE does not recommend routine surgery for ovarian endometrioma before assisted reproduction simply to improve live-birth rates because evidence does not show benefit and surgery may reduce ovarian reserve.

For deep endometriosis, decisions before assisted reproduction should be driven mainly by pain, anatomy, individual circumstances and patient preference because fertility benefit remains uncertain.

This reinforces an important point:

Treatment for sexual pain and treatment for infertility need to be coordinated, but they are not always the same treatment.

Partner Involvement

Where the patient is comfortable, I believe involving the partner can improve treatment.

The partner should understand that avoidance of intercourse does not necessarily mean loss of affection or attraction.

A woman may want intimacy very much but fear the pain that follows penetration.

Simple understanding can remove a great deal of emotional pressure.

Couples can temporarily focus on forms of intimacy that do not provoke pain while medical and pelvic-floor treatment progresses.

Can Endometriosis-Related Sexual Pain Cause Low Desire?

Yes.

Sometimes desire is affected directly by pain, fatigue or hormonal treatment.

More often, it falls because intercourse repeatedly hurts.

The brain learns:

sexual activity = pain.

A woman may therefore stop initiating intimacy even though she still loves and feels attracted to her partner.

Meta-analytic evidence shows that endometriosis affects not only pain but also desire, arousal, lubrication, orgasm and satisfaction.



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This is why reducing the patient's sexual problem to “dyspareunia” alone can miss much of the actual burden.

Depression, Anxiety and Emotional Health

Living with chronic pelvic pain, infertility and painful intercourse can be exhausting.

WHO recognizes depression and anxiety among the significant consequences associated with endometriosis.

Mental-health support should be offered when needed.

Again, this does not mean pain is psychological.

A patient can have biologically driven endometriosis and simultaneously need psychological support because chronic illness has affected her emotional health.

Endometriosis-Related Sexual Pain and the Unani System of Medicine

As a physician trained in the **Unani System of Medicine**, I consider one of its valuable clinical principles to be that the patient should be assessed as a complete individual rather than as one isolated symptom.

Official material from the Central Council for Research in Unani Medicine describes Unani treatment through approaches including:

- **Ilaj-bil-Ghiza — Dietotherapy**
- **Ilaj-bil-Tadbir — Regimental therapy**
- **Ilaj-bil-Dawa — Pharmacotherapy**
- **Ilaj-bil-Yad — Surgery or procedural treatment where applicable**

CCRUM also describes **Izala-i-Sabab**, addressing the causative factor, and a holistic assessment of lifestyle, constitution, physical state and emotional condition among the traditional principles of Unani treatment.

These principles can provide a useful framework for individualized supportive care.

How I Apply a Responsible Unani Approach

If a woman comes to me with endometriosis-related sexual pain, I do not believe the responsible approach is simply:

“Take one herbal medicine for painful intercourse.”



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First, we need to determine what is contributing to the pain.

Is deep endometriosis present?

Is there an ovarian endometrioma?

Are bowel or bladder lesions suspected?

Is pelvic-floor spasm contributing?

Is she experiencing vulvodynia or vestibulodynia?

Has central sensitization developed?

Is she trying for pregnancy?

Has she already undergone surgery?

Does she have anemia because of heavy menstrual bleeding?

Are constipation, poor sleep, chronic stress or metabolic problems worsening her quality of life?

Once these questions are answered, Unani principles can be incorporated appropriately rather than being used as a substitute for diagnosis.

Izala-i-Sabab — Addressing the Cause

The Unani principle of **Izala-i-Sabab**, or addressing the causative factor, is particularly relevant.

CCRUM describes identification and removal or correction of causative factors as a fundamental treatment principle.

In modern endometriosis care, I interpret this principle responsibly.

If deep bowel endometriosis is causing severe pain, that structural disease must be appropriately investigated.

If pelvic-floor spasm is a major driver, the muscles need rehabilitation.

If anemia is present, it needs correction.

If infertility is the priority, fertility planning must not be postponed indefinitely while the patient receives repeated pain treatment.

Traditional and modern reasoning can meet at one very sensible point:

Understand the problem before deciding how to treat it.



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Ilaj-bil-Ghiza — Dietotherapy

Diet plays an important role in overall health.

A balanced dietary plan can support:

- Healthy body weight
- Bowel function
- Nutritional status
- Iron intake where deficiency exists
- General metabolic health
- Energy and physical well-being

Constipation is particularly worth addressing in women whose pelvic pain or deep endometriosis also affects bowel comfort.

However, scientific honesty is important.

There is currently **no specific diet proven to eliminate endometriosis lesions or reliably cure endometriosis-related sexual pain.**

Diet should therefore be considered supportive rather than curative.

Ilaj-bil-Tadbir — Regimental and Lifestyle Care

Unani regimental principles encourage appropriate regulation of activity, rest and general lifestyle.

Within a modern integrative approach, useful components may include:

- Regular appropriate physical activity
- Sleep optimization
- Stress management
- Maintaining healthy weight
- Gentle mobility
- Management of constipation
- Relaxation techniques
- Attention to sexual and emotional well-being



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When pelvic-floor dysfunction is present, these general measures should complement specialist pelvic-floor physiotherapy rather than replace it.

Ilaj-bil-Dawa — Unani Pharmacotherapy

Unani medicine contains herbal and compound formulations traditionally used for women's reproductive and painful conditions.

However, I believe we must distinguish between **traditional therapeutic use and high-quality scientific evidence specific to endometriosis**.

Current mainstream guidelines do not establish a Unani herbal formulation as a proven treatment capable of removing endometriosis lesions or curing endometriosis-related sexual pain.

NICE states that evidence does not support traditional Chinese herbal treatments or supplements for treating endometriosis; similarly, robust clinical-trial evidence for Unani-specific endometriosis treatment remains insufficient.

Therefore, any Unani pharmacotherapy should be:

- Individualized
- Appropriately prescribed
- Quality controlled
- Reviewed for interaction with other medicines
- Used without delaying necessary gynecological investigation
- Integrated with evidence-based pain, fertility or surgical care when indicated

This is the standard I consider appropriate for responsible integrative practice.

Can Unani Medicine Cure Endometriosis?

At present, it would not be scientifically appropriate to claim that a particular Unani medicine has been proven in high-quality clinical trials to permanently cure endometriosis.

Endometriosis is a chronic disease for which even contemporary medical and surgical treatments do not guarantee permanent cure; WHO explicitly states that there is currently no known definitive cure.

The more defensible role of Unani medicine is as part of **individualized supportive care**, addressing general health, diet, lifestyle and selected symptoms while the patient receives appropriate gynecological evaluation and treatment.

I believe this is more useful to patients than making unrealistic promises.

The Specialized Saira Health Care Approach

At **Saira Health Care**, sexual pain associated with endometriosis should not be treated as merely a gynecological symptom.

Our focused work in **sexual disorders and infertility** makes it particularly important to examine the interaction between:

- Pelvic pain
- Sexual function
- Fear of penetration
- Pelvic-floor function
- Desire and arousal
- Relationship communication
- Fertility planning
- Reproductive health

My preferred approach is therefore **integrative and cause-oriented**.

My Clinical Framework for Endometriosis-Related Sexual Pain

First: Understand the pain

Is it deep or superficial?

Is it cyclical?

Does it occur only with penetration?

Does it continue afterward?

Second: Assess endometriosis properly

Where appropriate, specialist gynecological assessment and imaging should be obtained.



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Third: Identify additional pain mechanisms

Pelvic-floor dysfunction, bladder pain, vestibulodynia and sensitization should not be missed.

Fourth: Understand reproductive goals

Is the patient trying for pregnancy now, planning pregnancy later, or not seeking pregnancy?

This directly changes treatment choices.

Fifth: Address sexual health

A woman should be able to discuss desire, arousal, penetration, orgasm and relationship concerns without embarrassment.

Sixth: Build an individualized treatment plan

This may include modern gynecological treatment, pelvic-floor physiotherapy, sexual counselling, fertility management, lifestyle interventions and appropriately selected Unani supportive care.

Seventh: Refer when specialist intervention is needed

Deep bowel, bladder or ureteric endometriosis, complex endometriomas, severe infertility or difficult surgical disease may require a specialized endometriosis or fertility center.

That is not a failure of integrative medicine. Appropriate referral is part of good medicine.

Why I Do Not Recommend Repeatedly Forcing Intercourse for Pregnancy

This deserves particular emphasis.

Some couples with infertility are advised informally:

“Just keep trying around ovulation.”

But if the woman has severe deep dyspareunia, every attempt may increase pain, anxiety and pelvic-floor guarding.

Sexual activity can gradually become a medical procedure rather than intimacy.

If pain is severe enough to prevent adequate intercourse, we should treat the sexual pain while simultaneously evaluating fertility rather than simply instructing the couple to increase intercourse frequency.



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When Should a Woman Seek Specialist Evaluation?

Medical assessment is particularly important when sexual pain is accompanied by:

- Severe menstrual pain
- Chronic pelvic pain
- Infertility
- Painful bowel movements during periods
- Rectal bleeding associated with menstruation
- Urinary pain or blood in urine around menstruation
- Persistent pain despite hormonal treatment
- Ovarian endometrioma
- Severe pain after intercourse
- Symptoms affecting daily life
- Significant bowel or bladder symptoms

NICE recommends referral when symptoms persist, initial treatment is ineffective or poorly tolerated, or symptoms significantly affect everyday life. Suspected deep endometriosis, endometrioma or disease involving bowel, bladder or ureter warrants specialist referral.

Red-Flag Symptoms

Although endometriosis is a common explanation for chronic pelvic pain, not every new symptom in a woman with known endometriosis should automatically be attributed to endometriosis.

Prompt medical assessment is especially important with:

- New severe acute pelvic pain
- Fever
- Fainting
- Heavy unexplained bleeding
- Pregnancy with significant pelvic pain



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- Persistent blood in stool or urine
- New pelvic mass
- Unexplained weight loss
- Symptoms suggesting bowel obstruction

These situations may require urgent evaluation for other conditions.

Can Endometriosis-Related Sexual Pain Be Successfully Treated?

Many women can experience substantial improvement.

However, the outcome depends upon what is driving the pain.

A patient whose pain primarily comes from hormonally active lesions may respond well to medical suppression.

Another with localized deep disease may benefit from specialist surgery.

Another may need pelvic-floor rehabilitation.

Another may have central sensitization requiring multidisciplinary chronic-pain care.

And many women benefit from combinations of these approaches.

This is why the most appropriate question is not:

“What is the best medicine for painful sex in endometriosis?”

The better question is:

“What mechanisms are causing this particular woman's pain?”

Frequently Asked Questions

Is painful intercourse a common symptom of endometriosis?

Yes. Deep pain during or after intercourse is a recognized symptom and is specifically included by NICE among features that should raise suspicion of endometriosis.

Is endometriosis pain usually superficial or deep?

Endometriosis is particularly associated with deep dyspareunia, although superficial sexual pain can coexist due to pelvic-floor dysfunction, vulvodynia, vestibulodynia, dryness or other conditions.

Why is sex painful with endometriosis?



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Potential mechanisms include painful lesions, inflammation, adhesions, deep pelvic disease, pelvic-floor muscle overactivity and sensitization of the peripheral and central nervous systems.

Does more severe endometriosis always mean more sexual pain?

No. Pain severity does not correspond perfectly to disease stage because lesion location, pelvic-floor tenderness, bladder pain and nervous-system sensitization can substantially influence symptoms.

Can ultrasound detect endometriosis?

Ultrasound can identify ovarian endometriomas and many forms of deep endometriosis, but a normal scan does not exclude the disease.

Is surgery necessary to diagnose every case?

No. Modern guidelines increasingly use clinical assessment and imaging before surgery. Laparoscopy may still be considered when diagnosis remains uncertain, symptoms persist or surgical treatment is appropriate.

Can birth-control pills help pain during intercourse?

Combined hormonal contraceptives are among the treatments recommended by ESHRE for reducing endometriosis-associated dyspareunia and other pain symptoms when medically appropriate.

Can hormonal treatment cure endometriosis?

Hormonal treatment can suppress symptoms and disease activity but does not provide a guaranteed permanent cure. Symptoms may recur after therapy ends.

Can surgery improve sexual pain?

It can improve endometriosis-associated pain in selected patients, particularly when deep or structurally significant disease is present. However, pain can persist if pelvic-floor dysfunction or central sensitization also contributes.

Can pelvic-floor physiotherapy help?

Evidence increasingly suggests that physiotherapy can reduce endometriosis-associated pelvic pain and dyspareunia, although evidence specifically for improvement in overall sexual function remains less certain.

Does endometriosis cause infertility?

Endometriosis is associated with infertility. The mechanisms can include inflammation, adhesions, ovarian involvement and altered pelvic anatomy.

Can painful sex itself make pregnancy difficult?



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Yes. Severe dyspareunia can reduce the frequency or feasibility of vaginal intercourse, particularly during the fertile window, adding a functional barrier to conception.

Should hormonal treatment be used while trying to become pregnant?

Hormonal suppression can control pain but generally prevents conception during treatment and should not be used solely to improve fertility. Fertility-oriented management requires a different strategy.

Can Unani medicine help?

An individualized Unani approach can play a **supportive role** through diet, lifestyle, sleep, stress management, general health optimization and appropriately selected pharmacotherapy. However, there is currently insufficient high-quality evidence to claim that a specific Unani treatment cures endometriosis or reliably eliminates endometriosis-related sexual pain.

A Message to My Patients

When a woman tells me:

“Doctor, I love my husband, but I avoid intercourse because I know it will hurt,”

I want her to understand that avoidance does not necessarily mean that her desire or relationship has failed.

Pain changes sexual behavior.

When another patient tells me:

“My ultrasound is normal, so people say nothing is wrong,”

I explain that a normal ultrasound does not completely exclude endometriosis, and it certainly does not invalidate her pain. Current diagnostic guidance explicitly recognizes this.

When another patient says:

“I had endometriosis surgery but sex still hurts,”

I do not immediately assume that another operation is required.

We also have to examine pelvic-floor muscles, bladder pain, vulvar pain, sensitization and the psychological consequences of years of painful intercourse.

And when a woman trying for pregnancy says:

“Every month intercourse around ovulation has become painful and stressful,”



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I believe we should treat her pain and evaluate fertility together rather than simply telling her to tolerate it.

The objective of treatment is not merely to suppress symptoms.

It is to help a woman regain **physical comfort, sexual confidence, reproductive choice and quality of life.**

About Dr. Nizamuddin Qasmi

Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care

Focused Practice in Sexual Disorders & Infertility

Professional Qualifications and Training

BUMS — Hamdard University, Delhi

MD

CGO

Certificate in Infertility — MGBIMS, Delhi

Certificate in Urology — London, UK

Masters in Male Infertility — MasterHealthPro (HealthPro)

Integrated Sexual and Reproductive Health — ISRH, UNFPA

At **Saira Health Care**, Dr. Nizamuddin Qasmi's focused clinical work includes sexual disorders, male and female sexual-health concerns, infertility, reproductive counselling and individualized Unani supportive care.

For women affected by endometriosis-related sexual pain, the Saira Health Care approach emphasizes confidential sexual-health assessment, fertility considerations, patient education and individualized integrative support, with referral for gynecological imaging, specialist endometriosis surgery, pelvic-floor physiotherapy or fertility treatment when these are clinically required.

Conclusion

Endometriosis-related sexual pain is a complex manifestation of endometriosis that most commonly presents as deep dyspareunia but can affect the entire sexual experience.

The pain may arise from deep endometriotic lesions, inflammation, adhesions, pelvic-floor muscle dysfunction, bladder or vulvar pain, peripheral nerve sensitization and central pain processing. Modern research increasingly demonstrates that these mechanisms can overlap.



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Endometriosis also affects broader sexual function. Meta-analytic evidence shows reductions not only in the pain domain but also in desire, arousal, lubrication, orgasm and satisfaction.

Current evidence-based treatment includes appropriately selected analgesics, hormonal therapy, specialist surgery, pelvic-floor rehabilitation and multidisciplinary pain or psychosexual care. ESHRE specifically recommends hormonal options for endometriosis-associated pain and recognizes combined hormonal contraception as one option for reducing dyspareunia; surgery is also an established option for selected patients.

Newer treatments continue to become available. NICE added relugolix combination therapy and linzagolix with add-back therapy as options for selected patients in 2025, demonstrating how rapidly endometriosis management continues to evolve.

For women interested in pregnancy, treatment requires particular care because strategies that suppress endometriosis pain may temporarily prevent conception, whereas surgery and fertility treatments have different indications and trade-offs.

From an **integrative Unani perspective**, the traditional emphasis on individualized assessment, **Izala-i-Sabab**, dietotherapy, regimental care and whole-person health can provide a supportive framework. However, current scientific evidence does not justify claiming that Unani medicine alone has been proven to eradicate endometriosis or permanently cure associated sexual pain.

At **Saira Health Care**, my approach is therefore to bring these areas together: understand the woman's pain, identify contributing mechanisms, assess her sexual and reproductive goals, use responsible Unani supportive principles, and involve gynecology, pelvic-floor rehabilitation, pain specialists or fertility services whenever necessary.

Most importantly, I want women to remember:

Painful intercourse should never be accepted simply as the price of having endometriosis.

Persistent sexual pain deserves the same careful diagnosis, dignity and treatment as any other important symptom.

For more information:

<https://www.sairahealthcare.com/>

Book an appointment:

<https://www.sairahealthcare.com/Appointment.aspx>

Saira Health Care Pharmacy:

<https://pharmacy.sairahealthcare.com/>

Medical Disclaimer: This article is intended for patient education and professional health awareness. It does not replace an individualized gynecological examination, diagnosis or treatment plan. Persistent or severe pelvic or sexual pain, infertility, abnormal bleeding, significant bowel or urinary symptoms, or suspected deep endometriosis should be evaluated by an appropriately qualified healthcare professional. Hormonal medicines, Unani formulations, herbal products and supplements should be used only after appropriate assessment, particularly when pregnancy is being planned.



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