QRS 1010 Pelvicenter

Repetitive peripheral magnetic stimulation to correct functional pelvic floor disorders

Scientific documentation and medical information

Sexual dysfunction: anorgasmia

Publisher:

Industriering 3 FL-9491 Ruggell Tel.: +423 798 80 88 / +31630916144 (WhatsApp)

E-Mail: emiel.spiessens@qrs-international.com / emiel.spiessens@gmail.com

YouTube: QRS GERMANY

QRS MedWiss Service

definition

70% of all women are said to be more or less affected by orgasm problems [1] . However, this topic is dealt with in a relatively “keyword-like” manner. Because behind the general term "orgasm problems" there are a whole series of problems: lack of sexual desire, vaginal dryness [2] , poor excitability and pain during sexual intercourse, which are also influenced by postpartum complaints.

It is therefore correct to assume that there is not a solitary orgasm problem, but rather a 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 the female Viagra (flibanserin / pink Viagra), which was introduced in the USA with great publicity, has now turned out to be a flop with many side effects [3] . Breaking down FSD to pelvic floor function, however, reveals an important treatment option.

---

prevalence

In representative studies, 4 to 24% of the women questioned stated that they had problems with orgasm [4] , [5] , [6] . However, the surveys are not particularly meaningful, since the response rate for a sample survey (questionnaires) of almost 9,000 people was only around 56%.

Those women who were willing to compare their orgasm problems in their 30s to those in their 60s reported a worsening from 15.2% to 32.2% [7] . Other studies show that 42% of those surveyed had been unable to have an orgasm in the past few months [8] and the prevalence of female sexual dysfunction (FSD) is said to be 25 to 63% [9] .

In a representative, nationwide study in the USA, which was conducted by telephone survey (women between 30 and 70 years of age), sexual interest decreased with age. Accordingly, the prevalence of 60 to 70-year-old women was 61% [10] . According to a systematic review, 64% (16 to 75%) had problems with sexual desire, 35% (16 to 48%) had problems reaching orgasm, and 31% (12 to 64%) reported basic difficulties in becoming sexually aroused and 26% (7 to 58%) reported experiencing pain during intercourse [11] .

When it comes to childbirth, 24% of women say they still experience pain during intercourse, even after 18 months [12] . According to another study, 77% of first-time mothers complain of constant back pain even a year after giving birth.

Surprisingly, postpartum pelvic pain syndrome (PPS) not only affects vaginal births [13] (40%), but also caesarean sections. The differences in prevalence between vaginal and operative births equalize 6 to 11 years after delivery [14] .

pathogenesis

In principle, anyone can achieve an orgasm, although women are more susceptible to disturbances [15] . The extent to which it makes sense to use rPMS in the case of

sexual dysfunction in women or problems with orgasm depends primarily on whether the pelvic floor actually affects the ability to discharge. After evaluating a survey of 776 Hamburg and Leipzig women and men, the female orgasm was no more complicated and difficult to achieve than in men. According to this, women could at least reach the climax on their own (masturbation) just as safely as the man [16] - which ultimately speaks against an organic cause.

It can be stated that women who have a "strong pelvic floor" generally feel more sexual desire and a stronger orgasm [17] , [18] , [19] . The "sexual pioneers" Masters & Johnson have described a direct correlation between the strength of the M. pubococcygeus (MPC) and ileococcygeus (MICC) contractions and the intensity of an orgasm [20] .

However, the literature often only speaks of the "pelvic floor" in general, without going into detail about the individual muscle tasks during sexual arousal or in the overall orgasmic situation. It is undisputed that the pelvic floor muscles as a whole influence the intensity of sensation during vaginal penetration [21] and that the MPC and MIC are responsible for the involuntary contractions during orgasm [22] , [23] .

However, this does not refer to the frequency of orgasms (“clitoral or vaginal”), for which there is no confirmation to date [24] . However, since the base of the clitoris is connected to the MPC, sexual arousal should be derived from its contraction alone from a physiological point of view. The much invoked M. ischiocavernosus (MIC), which is often referred to in the relevant literature as the "orgasm muscle", seems to be only responsible for the pressure build-up in the clitoral cavernous bodies. And the M. bulbospongiosus (MBS) compresses the Vena dorsalis so that there is no rapid outflow of blood in the erectile tissue - whereby its pressure on the Bartholin glands located there increases the lubrication of the vaginal entrance.

It makes sense that the MIC and MBS are the muscles most commonly injured during childbirth. Of course, a general contraction of the pelvic floor always increases blood flow and triggers tumescence of the cavernous bodies [25] . In conclusion, it can be stated that a contraction of the pelvic floor 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 to be very individual because of a different vaginal anatomy ***[26]*** . However, it always depends on the stimulation quality (of the partner) and of course on the muscle tone. The clito-urethro-vaginal connection seems to be
so robust that even after a cliterectomy (surgical removal of the clitoris) it is still possible to describe this as an orgasm by tensing the pelvic floor and subsequent discharge [27] .

Even women who have completely damaged the spinal cord
(above the pelvic and hypogastric nerve area) can still have an orgasm after genital stimulation [28] . For example, the developer of Kegel training (pelvic floor training) is convinced that sexual sensation within the vagina is directly related to muscle tone and can be improved by muscle training and resistance training of the pubococygeus muscle [29] .

Coital pain after previous deliveries [30] can be related to inflammation [31], [32], adhesions after surgery [33], cysts on the ovary, an OAB [34] or even a malformation in the area of the genital organs. Often, however, there is a so-called vaginismus behind it, in which the muscles in the lower area of the vagina (probably for psychological reasons) contract involuntarily and thus make it possible for the penis to penetrate only with pain. This could, for example, be an attempt to compensate for weak fascial-ligamentous structures.

Cardiovascular stress, in turn, affects clitoral and vaginal blood flow, leading to loss of smooth muscle tissue and vaginal dryness [35]. Diabetes mellitus also produces consequential damage to nerves and vessels, which is directly noticeable in terms of sexual excitability and pleasure.

In addition, the menopause (“lack of estrogen”) has a relatively clear effect on all parameters of sexual dysfunction [36]. Last but not least, social factors should not be underestimated. after a modern woman cannot equally fulfill her various roles as employee, housewife, mother, friend and sex playmate [37].

---

conservative therapies

In the case of vaginal atrophy and reduced lubrication, the usual drug therapy attempt (“proven estrogen deficiency”) consists of local estrogen application or sex counseling. The daring assumption that up to 80% of all sex-medical problems can be solved in this way [38] is more wishful thinking than reality. Whether this will change with the approval of the melanocortin agonist bremalanotide remains to be seen.

Due to the different influencing factors of FSD and the strenuous procedure, active pelvic floor training (PFMT Pelvic Floor Muscle Training) is relatively rarely ordered, or it takes place as part of physiotherapeutic SUI or prolapse treatment, which also has a positive effect on sexual dysfunction as a "side effect". [39], which is confirmed by a systematic review [40].

The quality of sexual sensation improved in 39% of women (control group 5%) after pelvic floor exercises for genital prolapse [41]. There have been some (uncontrolled) studies by the inventor of Kegel training since the 1950s, according to which women who completed pelvic floor training because of urinary incontinence often reported increased vaginal sensations and an improved ability to have orgasms [42], [43].

Kegel's findings are supported by a retrospective correlational study, according to which pubococcygeus muscle strength is always higher in orgasmic women than in women who are unable to achieve orgasm [44]. This has been confirmed by a controlled study that predicts the relationship between MPC strength and an orgasmic response [45].

Another study also shows that women with a strong pelvic floor are more likely to engage in sexual activity [46]. If, for example, pelvic floor training is carried out at home (twice a day for 10 weeks/incontinence protocol Aukee [47]), the women in the active group achieve a significant improvement in sexual functions such as desire, arousal, lubrication, orgasm, satisfaction and coital pain. The overall score (FSFI)

rose from 13 to 32 points, while it deteriorated from 15 to 13 in the control group [48] .

Another study looked at women suffering from decreased sexual desire who received a PFMT for urinary incontinence. Through the exercise, 30% of the women regained their sexual desire, all women lost coital pain and a third improved their orgasmic problems [49] . Another literature review confirmed at least the general trend that the sexual areas of arousal, lubrication, orgasmic ability and desire can be improved in postpartum women through pelvic floor training. However, to what extent coital pain can benefit from this is not entirely clear [50] .

Findings on electrostimulation for sexual dysfunction are naturally rare, after the introduction of a vaginal stick electrode, which is also painful, only finds a few interested parties. There are now also electrostimulation devices for home use. Only to what extent the M. iliococcygeus can actually be trained with this is not entirely clear.

This must be distinguished from sacral neurostimulation, which is helpful in the case of neurogenic disorders (MS, paraplegia, etc.). In a study in which electrical stimulation was carried out - but only weekly - over a period of 8 weeks, desire, arousal and the ability to have an orgasm improved. In terms of lubrication and coital pain, however, no change was seen in either group [51] .

rPMS effect

The relevance of rPMS in female sexual dysfunction with regard to its sub-areas of pleasure and the ability to have an orgasm is basically revealed by an existing pelvic floor weakness and the clear results from the treatment of urinary incontinence (SUI), which primarily involves muscle strengthening and regaining cortical representation. The beneficial effects on sexual function [52] investigated in some studies (reviews) on incontinence therapy with the Pelvicenter rPMS also HYPERLINK "https://pelvicenter.com/wp-admin/post.php?post=129&action=edit" \l "_edn52" confirm the potential of rPMS therapy.

On the subject of postpartum pain syndrome (coital pain / dyspareunia), which also affects sexuality very strongly, there is also evidence from studies on neuromodulation and the training of insufficient or damaged muscles using rPMS [53] , [54] , [55] . Animal experiments (mouse) have shown that rPMS significantly minimizes the inflammatory infiltrate and scarring of damaged muscles and thus not only prevents post-traumatic muscle atrophy, but also increases muscle metabolism and the density of receptors for acetylcholine [56] .

However, dyspareunia can also occur independently of postpartum muscle damage due to hypertension or permanent contraction of the pelvic floor muscles [57] , [58] , [59] . The results of active pelvic floor training suggest [60] that rPMS is also fundamentally effective here.

Scope of treatment / therapy period

In order to enlarge the muscle cross-section of the pelvic floor and to intensify and expand the important cortical representation, the rMPS training should be carried out in the same way as in the treatment of SUI (2 to 3 times a week, 6 to 8 weeks). The choice of frequency settings should be in the upper range here. If there is hypertonicity in the pelvic floor that leads to coital pain, around 10 treatments should be considered sufficient. In order to achieve muscle relaxation, low to medium frequency treatment should be used [61] .

expectation of success

Based on the results of active pelvic floor training and the knowledge that rPMS has a much more intense effect, a significant increase in all sexual functions can be assumed on the basis of SFSI scoring. An example of this is intensive pelvic floor training carried out at home under biofeedback control (twice a day for 10 weeks), which resulted in a score increase in sexual desire (from 1.2 to 4.8 points), the ability to be aroused (1.5 to 5.7), lubrication (1.95 to 5.4), satisfaction (2 to 5.6) and coitus pain not quite as severe (4.6 to 5.68).

The overall score improved from 13.05 to 32.09, while it fell from 15.32 to 13.67 in the control group [62] .

The SFSI is a 19-item self-assessment instrument validated for women with arousal disorders, libido problems, orgasmic disorders, etc. [63] , [64] . A score of 0 means the person has not had sex in the past few months. A score of ≤ 26.55 indicates female sexual dysfunction [65] . This is also confirmed by studies according to which QRS Pelvicenter rPMS training of the pelvic floor led to a significant improvement in the FSD in all sub-areas of the SFSI or GRISS scoring. The result was retained even after 3, 6 and 12 months after the end of therapy [66] .

study situation

So far, two studies have been published on rPMS in female sexual dysfunction, which, however, do not refer specifically to FSD, but also examined the influence of rPMS on the sexual function of women in the course of incontinence treatment (SUI).

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

Result:

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

Study 2: Participation in therapy with the QRS Pelvicenter rPMS of 66 married couples, of which the 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 had not responded to treatment after 8 weeks could opt for an extension to 32 weeks. The GRISS questionnaire (Golombok Rust Inventory of Sexual Satisfaction) was used to check both partners.

This also contains 12 subscales such as erectile dysfunction (men), premature ejaculation (men), vaginismus (women), anorgasmia (women), lack of pleasure (men and women), avoidance behavior (men and women), dissatisfaction (men and women) , less frequent sexual intercourse and a lack of sexual communication [69] . Pelvic floor strength was measured using a perinometer.

Result:

6 months after the treatment, 53 of the couples (80.3%) were still available for the GRISS survey. Of the missing couples, 10 couples refused further questioning and 3 could no longer be reached. Both shortly after the end of treatment and 6 months later, there was a significant improvement in SUI symptoms and pelvic floor function. All sub-areas in the GRISS scoring also improved significantly ($p < 0.001$). This also referred to the subscales of rare sex, non-satisfaction, lack of ability to enjoy and vaginismus - with the improvement in "non-satisfaction" being most pronounced.

---

summary

With a prevalence of 40 to 45%, sexual dysfunction is one of the most common but often neglected diseases in women [70] . Above all, “lack of desire” (64%) and “anorgasmia” (35%) are mentioned, followed by problems with sexual arousal and pain during sexual intercourse.

Although partner problems, social conditions, the consequences of childbirth or an estrogen deficit in the menopause play a not insignificant role, a "strong pelvic floor" seems to be essential for sexual desire and the ability to have an orgasm. Here are mainly the Mm. pubococcygeus (MPC) and ileococcygeus (MICC) in the foreground, since these are also responsible for vaginal pleasure and the rhythmic contractions during orgasm.

Apart from the rather insignificant hormone substitution and couple therapy, the most effective of all means, pelvic floor training, has not been able to assert itself in the therapy of FSD. The banal reason is that most women shy away from the lengthy and strenuous training procedure of pelvic floor training or give up because of the effort.

With the QRS Pelvicenter rPMS, which has a disproportionately stronger effect on a muscle cross-section enlargement of all muscles of the pelvic floor and also strengthens the important cortical representation, an effective and easy-to-implement procedure is available to which all areas of sexual dysfunction react with a significant improvement!

This also applies to vaginismus (“hypertonic pelvic floor”) and postpartum coitus pain, especially since rPMS in the latter not only significantly minimizes inflammatory infiltrates and scarring of damaged muscles, but also increases the muscular receptor density for the messenger substance acetylcholine again.

Sources

[1] https://www.news.at/a/70-frauen-orgasmusproblemen-118230
[2] Goldstein I, Berman JR. Vasculogenic female sexual dysfunction: vaginal engorgement and clitoral erectile insufficiency syndromes. Int J Impot Res 1998; 10(Supp 2): S84 - S90
[3] Jaspers L, Feys F, Wichor M et al. Efficacy and safety of Flibanserin for the treatment of hypoactive sexual desire disorders in women. A systematic review and meta-analysis. JAMA Intern Med. 2016;176(4):453-462
[4] Ventegodt S. Sex and the quality of life in Denmark. Arch. Sex. Behav 1998;27:295-307
[5] Laumann EO, Paik A, Rosen RC. Sexual dysfunction in the United States. JAMA 1999;281:537-544
[6] Rosen RC et al. Prevalence of sexual dysfunction in women: results of a survey study of 329 women in an outpatient gynecological clinic. J Sex Marital Ther 1993 case; 19(3): 171-88
[7] Hisasue S et al. Prevalence of female sexual dysfunction symptoms and its relationship to quality of life: a Japanese female cohort study. Urology 2005; 65(1): 143-8
[8] Read S, King M, Watson J. Sexual dysfunction in primary medical care: prevalence, characteristics and detection by the general practitioner. J. Public Health Med 1997;19:387-391
[9] Laumann EO, Paik A, Rosen RC. Sexual dysfunction in the United States. Prevalence and predictors. JAMA 1999; 281(6):537-544
[10] West SL et al. Prevalence of low sexual desire and hypoactive sexual desire disorder in a nationally representative sample of US women. Arch Intern <Med 2008; 168:1441-1149
[11] Hayes RD et al. What can prevalence studies tell us about female sexual difficulty and dysfunction. J Sex Med 2006; 3(4):589-595
[12] McDonald EA et al. Dyspareunia and childbirth: a prospective cohort study. BJOG. 2015; 122(5): 672-679
[13] Mannion CA et al. The influence of back pain and urinary incontinence on daily tasks of mothers at 12 month postpartum. PLoS One 2015; 10(6): e0129615
[14] Blomquist JL et al. Pelvic pain and mode of delivery. Am J Obstet Gynecol 2014; 210(5): 423.el.-423.e6
[15] Eicher W. Female orgasm. Disorders of orgasm and treatment possibilities. gynecologist 1993; 26(3): 177-183
[16] Matthiesen, Silja, Hauch, Margret. Disappearance of gender differences? Resolution, reversal, or continuity of traditional sex differences in sexual behavior. An empirical study on three generations. Behavior therapy and psychosocial practice. Communications from the DGVT. 2004; 36 , 491-508
[17] Martinez CS et al. Women with greater pelvic floor muscle strength have better sexual function. Acta Obstet Gynecol Scand 2014; 93(5): 497-502
[18] Sacomoria C et al. Pelvic floor muscle strength and sexual function in women. Fisioter Mov 2015; 28(4): 657-665
[19] Lowenstein L et al. Can stronger pelvic muscle floor improve sexual function. Int Urogynecol J 2010; 21(5): 553-556
[20] Masters WH, Johnson VE. Human sexual response. Little, Brown, Boston. 1966
[21] Graber B, Kline-Graber G. Female orgasm: role of pubococcygeus muscle. J Clin Psychiatry 1979; 40(8): 348-351
[22] Lowenstein L et al. Can stronger pelvic muscle floor improve sexual function. Int Urogynecol J 2010; 21(5): 553-556
[23] Piassarolli VP et al. Pelvic floor muscle training in female sexual dysfunctions. Rev Bras Ginecol Obstet 2010; 32(5): 324-40
[24] Chambless DL et al. The pubococcygeus and female orgasm: a correlational study with normal subjects. Arch Sex Behav 1982:11:479-490
[25] Messé MR, Geer JH. Voluntary vaginal muscular contractions as an enhancer of sexual arousal. Arch Sex Behavior 1985; 14(1): 13-28
[26] Jannini A, Buisson O, Rubio-Casillas A. Beyond the G-Spot: Clitourethovaginal complex in the female orgasm. Nat Rev Urol 2014; 11: 531-538
[27] Berg RC, Denison E. Does female genital mutilaton/cutting (FGM/C) affect women's sexual functioning. A systematic review of the sexual consequences of FGM/C. Sex Res Soc Policy 2011; 9: 41-56
[28] Komisaruk BR, Gerdes CH, Whipple B. Complete spinal cord injury does not block perceptual responses to genital self-stimulation in women. Arch Neurol. 1997 54(12):1513-20
[29] Cone AH. Sexual functions of the Pubococcygeus muscle. Wet J Surg Obstet Gynecol 1952; 60:521-524
[30] McDonald EA et al. Dyspareunia and childbirth: a prospective cohort study. BJOG. 2015; 122(5): 672-679
[31] Butrick CW. Interstitial cystitis and chronic pelvic pain. New insights into neuropathology, diagnosis, and treatment. Clin Obstet Gynecol. 2003; 46(4):811-23
[32] Peters KM et al. Sexual function and sexual distress in women with interstitial cystitis: a case-control study. Urology 2007; 70(3): 543-547
[33] Paul's RN. Impact of gynecological surgery on female sexual function. Int J Impot Res 2010; 22(2): 105-114
[34] Wehbe SA, Whitmore K, Kellogg-Spadt S. Urogenital complaints and female sexual dysfunction (part 1). J Sex Med 2010; 7(5): 1704-1713
[35] Goldstein I, Berman JR. Vasculogenic female sexual dysfunction: vaginal engorgement and clitoral erectile insufficiency syndromes. Int J Impot Res 1998; 10(Supp 2): S84 - S90
[36] Pitsouni E, Grigoriadis T, Douskos A et al. Efficacy of vaginal therapies alternative to vaginal estrogens or sexual function and orgasm of menopausal women: a systematic review and meta-analysis of randomized controlled trials. Eur J Obstet Gynecol Reprod Biol. 2018; 229: 45-56
[37] Butcher J. Female sexual problems I: loss of desire - what about the fun. BMJ 1999; 318(7175): 41-43
[38] Bayerle-Eder M, Dadak C. Female sexual dysfunction. ÖAZ 2015; 20:40-42
[39] Stelzhammer C. Pelvic floor and female sexuality. spectrum urology. 2016; 2: 1-2
[40] Ferreira CH, Dwyer PÖL, Davidson M et al. Does pelvic floor muscle training improve female sexual function. A systematic review. Int Urogynecol J 2015; 26(12): 1735-1750
[41] Braekken IH, Jajida M, Ellström EM, Bo K. Can pelvic floor muscle training improve sexual function in women with pelvic organ prolapse. a randomized controlled trial. J Sex Med 2015; 12(2): 470-480
[42] Kegel A. Physiologic therapy for urinary stress incontinence. J Am Med Assoc 1951; 146: 915-917
[43] Kegel A. Sexual functions of the pubococcygeus muscle. West J Surg Obstet Gynecol. 1952; 60: 521-524
[44] Graber B, Kline-Graber G. Female orgasm: role of pubococcygeus muscle. J Clin Psychiatry 1979; 40(8): 348-351
[45] Chambless D et al. The pubococcygeus and female orgasm: A correlational study with normal subjects. Arch Sex Behavior 1982; 11:479-490
[46] Kanter G et al. A strong pelvic floor is associated with higher rates of sexual activity in women with pelvic floor disorders. Int Urogynecol J 2015; 26(7): 991-996
[47] Aukee P et al. The effect of home biofeedback training on stress incontinence. Act Obstet Gynecol Scand. 2004; 83(10): 973-977
[48] Basgol S, Oskay U. Examining the effectiveness of home-based pelvic floor muscle training in treating sexual dysfunction in women. Int J Car Sci 2016; 9(1): 135-143
[49] Beji NK, Yalcin O, Erkan HA. The effect of pelvic floor training on sexual function of treated patients. Int Urogynecol J Pelvic Floor Dysfunct 2003; 14(4): 234-238
[50] Willians A. The role of pelvic floor muscle exercise in the treatment of female sexual dysfunction. Literature Review. J Assoc Charter Physiother Women Health 2014; 115:22-29
[51] Aydin S et al. Effect of vaginal electrical stimulation on female sexual functions: a randomized study. J Sex Med 2015; 12:463-469
[52] Ferreira CH et al. Does pelvic floor muscle training improve female sexual function? A systematic review. Int Urogynecol J 2015; 26(12): 1735-1750
[53] Polkey MI, Luo Y, Guleria R et al. Functional Magnetic Stimulation of the Abdominal Muscles in Humans. Am J Respir Critic Care Med. 1999; 160(2):513-522
[54] Swallow EB, Gosker HR, Ward KA, et al. A novel technique for nonvolitional assessment of quadriceps muscle endurance in humans. J Applied Physiol, 2007; 103(3):739-746
[55] Taylor JL. Magnetic muscle stimulation produces fatigue without effort. J Appl Physiol. 2007; 103(3):733-734
[56] Stoelting MNL, Arnold AS, Haralampieva D et al. Magnetic stimulation supports muscle and nerve regeneration after trauma in mice. Muscle Nerve 2016; 53(4): 598-607
[57] Butrick CW. Pathophysiology of pelvic floor hypertonic disorders. Obstet Gynecol Clin North Am. 2009;36(3):699–705
[58] Sinaki M, Merritt JL, Stillwell GK. Tension myalgia of the pelvic floor. Mayo Clin Proc. 1977; 52(11):717-722
[59] Faubion SS, Shuster LT, Bharucha AE. Recognition and management of nonrelaxing pelvic floor dysfunction. Mayo Clin Proc. 2012; 87(2):

187-193
[60] Ger GC, Wexner SD, Jorge JMN, et al. Evaluation and treatment of chronic intractable rectal pain—A frustrating endeavor Dis Colon Rectum. 1993;36:139-145
[61] Beaulieu LD, Schneider C. Effects of repetitive peripheral magnetic stimulation on normal or impaired motor control. A review. Neurophysiol Clin. 2013; 43(4): 251-260
[62] Basgol S, Oskay U. Examining the effectiveness of home-based pelvic floor muscle training in treating sexual dysfunction in women. Int J Car Sci 2016; 9(1): 135-143
[63] Rosen R et al. The Female Sexual Function Index (FSFI): A multidimensional self-report instrument for the assessment of female sexual dysfunction. J Sex Marital Ther. 2000; 26(2): 191-208
[64] Berner MM. Validity and Reliability of the German Female Sexual Function Index (FSFI-d). Obstetrics Frauenheilkd 2004; 64(3): 293-303
[65] Wiegel M et al. J Sex Marital Ther 2005; 31:1-20
[66] Chung SY, Jung HC. Effects of functional magnetic stimulation therapy on lower urinary tract symptoms and sexual function in female patients with stress urinary incontinence. Korean J Urol. 2003;44(10), 993-998
[67] Chung SY, Jung HC. Effects of functional magnetic stimulation therapy on lower urinary tract symptoms and sexual function in female patients with stress urinary incontinence. Korean J Urol. 2003;44(10), 993-998
[68] Lim R et al. Effect of pulsed magnetic stimulation on sexual function in couples with female stress urinary incontinence partners. J Sex Marital Ther. 2018; 44(3): 260-268
[69] Rust J. Golombok S. The GRISS: a psychometric instrument for the assessment of sexual dysfunction. Arch Sex Behavior. 1986; 15(2), 157-165
[70] Lewis RW, Fugl-Meyer KS, Corona G et al. Definitions/epidemiology/risk factors for sexual dysfunction. J Sex Med 2010, 7 (4 Pt 2) **:** 1598-1607