NOVEMBER 8-9, 2025

VIRTUAL

MEN'S PELVIC HEALTH SUMMIT

CLINICAL SUMMARY

CLINICAL ANODYSPAREUNIA: WHEN RECEPTIVE ANAL INTERCOURSE IS PROBLEMATIC

PRESENTED BY DR. THOMAS GAITHER, MD, MAS

DAY 1 • SESSION 4

CLINICAL SUMMARY

Overview

Clinical anodyspareunia is defined as severe, bothersome pain during receptive anal intercourse. This pain is significant enough to disrupt sexual activity, often leading individuals to avoid intercourse despite wanting to engage. While receptive anal intercourse is often assumed to be inherently painful, Dr. Gaither emphasizes that most people who engage regularly report no pain. When pain is present, it is usually related to underlying conditions that are identifiable and treatable.

Key Clinical Themes

Definition: Anodyspareunia = severe, bothersome pain with receptive anal intercourse.

Misconceptions:

• Receptive anal intercourse is only for gay men (in reality, it is a sexual behavior across all genders and orientations).

• Pain is a normal part of receptive anal intercourse (most people report no pain when healthy and properly prepared).

Common Presentations:

• Individuals who previously enjoyed receptive anal intercourse and now experience pain.

• Bleeding during or after receptive anal intercourse (often reported as bleeding with bowel movements).

Red Flags:

• Persistent bleeding (may indicate hemorrhoids, fissures, STIs, or anal/colorectal cancer).

• Neurological symptoms (numbness, radiating pain, dysesthesias) suggesting possible nerve root pathology.

• Masses or abnormal tissue on exam (possible anal cancer or HPV-related lesions).

CLINICAL SUMMARY

Differential Diagnosis:

Anal fissures: Tearing pain, worse with bowel movements, prolonged pain after defecation. Cause is mostly hard stool, constipation.

Anal cancer: Often misdiagnosed as hemorrhoids; requires anoscopy and biopsy of friable lesions.

STIs (gonorrhea, chlamydia, HPV): May cause bleeding, inflammation, warts.

Hemorrhoids: Most common cause of rectal bleeding in the U.S.

IBD (Crohn's/ulcerative colitis): Chronic inflammation contributing to pain/bleeding.

Practical In-Clinic Strategies

Assessment:

History: Always ask if pain is lifelong or new-onset. New pain following previously pleasurable experiences suggests acquired dysfunction (e.g., pelvic floor dysfunction, increased tone).

Subjective cues: Reports of bleeding, urinary symptoms, or persistent pelvic/testicular pain.

Physical exam:

• Visual inspection: Look for hemorrhoids, fissures (typically at 12 o'clock position near coccyx), HPV lesions.

• Digital rectal exam: Sweep circumferentially for induration, asymmetry, or tenderness. Prostate should feel spongy (like the thenar eminence); a hard/nodular feel is abnormal.

• Note any reproduction of pain or bleeding with palpation.

Treatment Strategies:

Pelvic floor therapy: First-line for pelvic floor dysfunction, anodyspareunia. Many patients experience rapid improvement.

Topical medication: Diltiazem 2% cream (compounded) applied externally or intrarectally for sphincter relaxation; extrapolated from fissure management and effective in pelvic floor pain.

Botulinum toxin (Botox): Consider for refractory pelvic floor or sphincter spasm when conservative care fails.

CLINICAL SUMMARY

Address contributing conditions:

• Treat hemorrhoids, STIs, IBD as indicated.

• Refer for colorectal or urology evaluation when cancer or structural pathology is suspected.

Communication strategies:

• Avoid assumptions about partner gender or sexual orientation.

• Focus on sexual behaviors and desired activities rather than labels.

• Normalize discussion of anal pain and sexual health to reduce shame and stigma.

Case Example:

A 26-year-old man develops pain with receptive anal intercourse after initially pleasurable experiences. Symptoms include persistent pelvic/testicular pain and urinary complaints. Exam is normal except for tenderness on pelvic floor muscle palpation. Pelvic floor therapy led to significant improvement after several sessions.

Final Notes

• Most cases of clinical anodyspareunia are treatable with a combination of pelvic floor therapy, topical relaxants, and, if necessary, procedural interventions.

• Persistent bleeding or abnormal exam findings must be referred promptly for further evaluation to rule out cancer or serious disease.

• Creating a welcoming, nonjudgmental environment is critical for patient disclosure and effective treatment.

Recommended Resources

Anorectal Sexual Function Index (ARSFI): Free 19-item validated questionnaire assessing pleasure, pain, urinary and bowel symptoms during receptive anal intercourse. Helpful for screening and clinical tracking.

Referral Network:

Pelvic health therapists, Urologists, Colorectal surgeons, Sex therapists, Neurologists (for pelvic radiculopathy/ dysesthesias)