Vulvodynia- What can a Gynecologist do?

Jeff Dempster MD FRCSC
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- Case History
- Definition of Disorder
- Prevalence
- Etiology and Diagnosis
- Treatment Options
Mary V

25 y.o. G0P0 on Marvelon 21
3 sexual partners-current partner for 1 year
Stopped having intercourse 2º pain 6 mos ago
Treated 6 times for yeast infections
Burning pain with penetration, worse with thrusting
Boyfriend says she is too small
Vulvodynia

‘Vulvar discomfort, most often described as burning pain, occurring in the absence of relevant visible findings or a specific, clinically identifiable, neurologic disorder’
Practically

- Vulvar pain with no evidence of other dermatologic explanation
- Pain is out of context with stimuli
  - Allodynia- pain in response to something not normally perceived as a painful stimulus
  - Hyperpathia-stimulus causes greater pain than would normally be expected
- Pain described as burning, irritating, sharp or prickly, rarely described as pruritic
History

Thomas TG, 1874
- ‘It consists of an excessive sensibility of the nerves supplying the mucous membrane of some portion of the vulva’

Skene AJC, 1889
- ‘Characterized by a supersensitiveness of the vulva. When, however, the examining finger comes in contact with the hyperaesthetic part, the patient complains of pain, which is sometimes so great as to cause her to cry out.’
Mary V

- You are the 3rd person she has seen
- Told her vulva is normal so she must have chronic yeast infections and given long-term prescription for Diflucan
- Burning occurs with IC as well as touch and tampon insertion
- She has tried lubricants and no change
- She feels she is ‘going crazy’
- Boyfriend accusing her of seeing someone else
- Has irritable bowel
Clues to Diagnosis

- Comes on only with penetration, oral sex may be ok, orgasm ok
- Tight clothes
- Partner touch
- Riding a bike
- Tampon use
- Prolonged sitting
Rule Out Other Causes

- Allergic vulvitis
- Chronic candida - needs discharge proven to be candida by microscopy or culture
- Lichen sclerosis
- Lichen planus
- Vulvar atrophy
- VIN
- Pudendal canal syndrome (unilateral usually)
Diagnosis

- History (patient localization not always helpful, i.e. deep vs. superficial)

- Physical exam
  - Normal vulva- exclude dermatoses, if uncertain treat and re-examine
  - Allodynia to Q-tip touch
    - May sometimes see hyperemia following touch
Diagnosis

Diagnosed using Friedrich’s Criteria:

- Severe pain on vestibular touch or attempted vaginal entry
- Tenderness to pressure localized within the vulvar vestibule
- No evidence of physical findings except for varying degrees of erythema

Examination

- Always look first and test with Q-tip before introducing speculum
- Indent about 3-5 mm working from outer labia into hymenal ring
- Single finger digital exam at end to assess pelvic musculature
- +/- speculum exam
Diagram from *The Vulvodynia Survival Guide*, reproduced with permission of author, Howard I. Glazer, Ph.D.
Vaginismus

- Generally will coexist with vulvodynia, likely a protective response
- May actually see muscles contract when you go to examine woman
- Use single finger in introitus
- Avoid speculum unless needed to rule out other diagnosis
Etiology

What it is NOT
  – Infection- HPV
  – Chronic yeast
  – Inflammation
What it likely may be

- A central or peripheral alteration of nerve function or interpretation of neural signals at the level of the cortex or the spinal cord
  - Animal models support both central and spinal cord etiologies
  - Have demonstrated lower pain thresholds at sites other than the vulva
  - ?conflicting evidence on abuse- may not be related
Mary V

- Normal vulva on examination
  - No yeast on microscopy
  - No discharge
- Q tip showed +++ burning at 5 and 7 o’clock just outside hymenal ring
- Single finger digital exam showed vaginimus, pressure on muscles reproduced pain felt with thrusting
ISSVD Classification

Vulvodynia
- Localized (vestibulodynia, clitorodynia)
  - Provoked
  - Unprovoked
  - Mixed
- Generalized
  - Provoked
  - Unprovoked
  - Mixed
Abandoned Terms

- Essential vulvodynia
- Dysesthetic vulvodynia
- Vulvar vestibulitis syndrome
- Vulvar dyesthesias
Mary V

- Localized, Provoked Vulvodynia

- Discarded term of vestibulitis to remove confusion around inflammation/infection
Subtypes

- Localized
  - Common
  - Age 20-50
  - 2 subtypes in my experience, always had vs. precipitated by some event

- Generalized
  - Uncommon
  - Older age, often post-menopausal
  - May have precipitants, radiation, surgery etc…
Prevalence

- Recent phone survey, Arnold et. al, Feb 2007
- Incidence 3.8 % (pain > 6 mos)
- Lifetime Prevalence 9.9%
- 45% Adverse effect on sex life
- 27% Adverse effect on lifestyle
Results from a self-report survey of vulvodynia patients administered by the National Vulvodynia Association

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Number surveyed</th>
<th>Have It</th>
<th>Suspect It</th>
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<tbody>
<tr>
<td>Chronic Fatigue</td>
<td>1566</td>
<td>12.6%</td>
<td>19.9%</td>
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<tr>
<td>Endometriosis</td>
<td>1452</td>
<td>15.6%</td>
<td>4.4%</td>
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<td>Fibromyalgia</td>
<td>1547</td>
<td>20.0%</td>
<td>15.4%</td>
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<tr>
<td>Interstitial Cystitis</td>
<td>1662</td>
<td>25.2%</td>
<td>22.0%</td>
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<tr>
<td>Irritable Bowel</td>
<td>1675</td>
<td>34.9%</td>
<td>15.8%</td>
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<tr>
<td>Low Back Pain</td>
<td>1729</td>
<td>55.5%</td>
<td>-</td>
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<tr>
<td>Migraine Headaches</td>
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<td>31.2%</td>
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<tr>
<td>Chemical Sensitivities</td>
<td>1595</td>
<td>27.2%</td>
<td>18.2%</td>
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<tr>
<td>Other Chronic Pain</td>
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<td>40.5%</td>
<td>-</td>
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</table>
Mary V

- Relieved to be given a diagnosis
- Wants to get more information
- Wonders if she will ever have sex comfortably again?
Treatment

- Validate their problem
- Not all in their head although can have significant psychological and relationship sequelae
- Vaginismus almost always coexists
Vulvar hygiene

- Minimize any irritants
  - Cotton underwear
  - No fabric softeners or dryer sheets
  - Non-irritant soaps to vulva and clothes, Dove or water only, Ivory Snow for wash
  - No scented products
  - Underwearless as much as possible
  - Avoid pantyhose
Protective Creams

- Particularly around menses
  - Silicone barrier creams
  - Vaseline
  - Zincofax etc…

- Lubricants **always** with intercourse
  - KY liquid, Astroglide, Slippery Stuff, Oh My!

- Some woman may manage with just xylocaine 2% jelly prn
Treatments

- Mainly based on expert opinion, few controlled trials with significant numbers of patients
Mary V

- Treatment goal is to get her comfortable most of the time, may not be absolutely pain free and may fluctuate over time
- Some woman seem to have a natural improvement
- No long-term studies on natural history
  - My experience is that recent onset more likely to improve
  - Lifelong very difficult and Generalized very difficult
Prognosis

- No real data
- Most treatment studies will show approx. 70% improvement
- Some suggestion that overall about 50% of women will improve
- I see large numbers of referred women and infrequent that we can’t find something that will help to some extent
- minimum 2 month trial of anything before increasing dose substantially or changing treatment
- once comfortable I recommend 6 months before trying to taper treatment, some women cannot taper at all
- unless fairly mild I recommend stopping attempts at penetrative IC until they are feeling somewhat in control of pain
Treatment

- Topical Medications
  - Estrace 0.01% in Glaxo base, qhs or bid
  - Xylocaine 2% jelly qid or prn (can also try EMLA, avoid benzacaine)
  - Amitriptyline 2%/baclofen 2% in water washable base
  - Zostrix- topical capsaicin- apply for 20 minutes and wash off- counter-irritant
No Role

- antifungals
- corticosteroids

If these are necessary then they need re-evaluation to see if they actually have vulvodynia
Oral Medications

- Tricyclic antidepressants
  - Amitriptyline
  - Nortriptyline
  - Desipramine
    - start low and go slow, 10 mg nightly, increase after 2 weeks, leave at that dose for 6 weeks
    - I go up to 75 mg if tolerated
    - do not stop suddenly, wean
Venlafaxine (Effexor XR)
- 37.5 mg daily
- increase after 1 month to 75 mg
- can go up to 150 mg
- wean slowly!!!
Anticonvulsants

- Gabapentin (Neurontin)- 300 mg daily, increase weekly by 300 mg until tid
- can go up to 3600 mg but I usually stop at 1800 mg
- Carbamazepine- I have never used
- Pregabalin (Lyrica)- 75 mg bid and increase after 1 month to 150 mg bid
Trigger Point Injections

- Occasionally helpful when there is just one or two painful spots only
- 1 injection of 2-4 mg Kenalog in xylocaine 1 or 2%, if helpful can repeat once
Low oxalate diet

- ????????????????????????????
Physiotherapy

- Biofeedback/pelvic floor physiotherapy
  - need to find someone in your area
  - we have one physiotherapist with this interest in Halifax area
  - abnormally high tone in pelvic floor a common problem, also helps with vaginismus
Surgery

- Left as last resort, generally vestibulectomy, sparing urethral area
Case Reports

- acupuncture
- Botox
- many ‘natural’ products
Vaginismus

- Must be addressed as well
  - physiotherapy/biofeedback
  - ‘reverse’ Kegel exercises
  - dilators, vibrator or candles
Sex Therapy

- mostly supplying information
- try to involve partner, often complex sexual dynamics by the time diagnosis is made
Mary V

- initially on Estrace with mild improvement
- added amitriptyline but couldn’t tolerate 20 mg because of sedation
- changed to nortriptyline and found improvement of 50%, up to 35 mg nightly
- added qid topical xylocaine jelly and got 80% improvement
- has worked on reverse Kegels and has IC most occasions comfortably
Summary

- This is a pain disorder
- Multiple treatments
- You won’t be able to fix everyone but you can help a significant number of women
- Don’t underestimate the importance of being able to give them a diagnosis and just listening
Patient Information

- www.ISSVD.org
- www.NVA.org
- www.vaginismus.com

Books
- The V Book: A Doctor’s Guide to Complete Vulvovaginal Health by Elizabeth Gunter Stewart, MD and Paula Spencer
- The Vulvodynia Survival Guide: How to Overcome Painful Vaginal Symptoms & Enjoy an Active Lifestyle by Howard I. Glazer, Ph.D. and Gae Rodke, M.D.