MSHC
MELBOURNE SEXUAL HEALTH CENTRE

Vulvodynia fact sheet

Also known as vulval pain

Vulvodynia or vulval pain is the term used to describe pain or discomfort at or around the vaginal opening. This pain happens without an obvious ongoing cause.

Quick facts

- Vulvodynia means vulval pain
- There are two types of vulvodynia, which can overlap

What is this?

Vulvodynia means vulval pain. There are two types of vulvodynia, which can overlap.

Localised provoked vulvodynia (LPV)

Localised provoked vulvodynia is discomfort or pain which happens when:

- the vaginal opening, or the 'vestibule', is touched or
- anything is put into the vagina, including a tampon

This discomfort or pain occurs in the absence of an obvious ongoing cause. The skin looks normal.

Spontaneous generalised vulvodynia (SGV)

This pattern of discomfort affects the whole vulva, or different areas of the vulva at different times, without any direct pressure or anything being in the vagina.

How do you get it?

The exact cause of vulvodynia and other chronic pain is not known. However, there is no single cause.

Common triggers of vulval pain include:

- frequent skin inflammation
- candida (thrush), even if itch and discharge are subtle
- urinary infections
- difficult to control dermatitis
- very occasionally genital herpes may be involved

All infections need prompt and accurate treatment.

Vulvodynia is treated as chronic pain and may be associated with pain conditions affecting other parts of the body.

For example:

- irritable bowel
- irritable bladder
- migraine
- fibromyalgia
- back and jaw pain
- chronic fatigue syndrome

Persistent triggers causing inflammation contribute to chronic pain. These triggers of chronic pain include:

- other painful conditions of the pelvis or hip and back
- genetic predisposition to pain
- mood problems
- poor sleep
- chronic stress

There is a change in sensitivity of nerve endings and associated pelvic floor muscle overactivity. Recent research using brain scans shows that there are also changes in brain function associated with chronic pain and so the sensations of pain continue despite the absence of an obvious cause. The nerves in the area that is painful can also produce their own pain impulses, so pain increases. Treatment aims to reverse these changes. It is important to remember that the vulva and vagina are healthy, but that the sensitivity has changed. Mostly these improve with treatment and time.

Wart virus (HPV) doesn't cause vulvodynia, although its treatments often irritate, and the skin nearby is often dry.

Importantly, chronic vulval pain does not usually interfere with pregnancy or the method of childbirth.

What are the symptoms?

Localised provoked vulvodynia (LPV)

Symptoms of LPV can include:

- pressure on the opening of the vagina, also known as the 'vestibule', is felt as pain
- touching with a cotton bud may produce a ‘cut glass’ burning or tearing feeling
- the clitoral area may be involved as well
- vestibular pain may be felt during arousal before any direct touching happens, although this is uncommon
- urinary burning and frequency can accompany vulval discomfort or occur alone with the same triggers
- discomfort tends to persist minutes to days afterwards
- pain may occur with the first ever vaginal touch or penetration, or after years of comfortable touch and intercourse

Spontaneous generalised vulvodynia (SGV)

Symptoms of SGV can include:

- vulval pain felt as a burning sensation
- a sensation of prickling, dryness or mild itch in the vulval area

In cases of SGV, when something is put in the vagina it usually does not cause pain. If there is burning nearby then it is not aggravated by penetration. Again the skin looks healthy.

Vulval discomfort

Vulval discomfort related to LPV and SGV may range from none unless the area is touched, to frequent vulval awareness whilst sitting, walking or especially bicycling and horse riding. Tight clothing may aggravate vulval discomfort. Vulval discomfort may improve and worsen over time. Intercourse may be possible, with discomfort only at the very initial stage, or may be too uncomfortable to attempt at all. Often the pelvic floor muscles will learn to tense as a protective behaviour, and this will worsen the pain.

Afterburn

'Afterburn-may occur after intercourse, lasting minutes to hours to days. This type of burning or tenderness that persists after sex is typical of chronic pain when there are no irritants or infections present.

Burning or discomfort may similarly happen after medical examination with a cotton tip or internal exam. Relief is often gained by a cool compress or saltwater soak. You can then apply a bland moisturiser, such as Dermeze®.

Urinary symptoms

Urinary symptoms often occur in vulval pain conditions, even without true bladder infection. Urinary symptoms include:

- burning sensation during urination
- urinary frequency

This is because the bladder and urethra and vulva develop from the same type of tissue and share their nerve supplies. There is also 'cross talk'-between the pelvic organs and muscles, so pain in one can cause symptoms in the other.

How do you test for it?

A diagnosis of vulvodynia is made by your doctor carefully detailing your symptoms and a physical examination. Skin disease and infection are excluded. A swab may be taken to exclude thrush. A cotton wool bud is used to map out the area of discomfort. Pelvic floor muscle function and tenderness will be assessed during a gentle examination. In almost all cases the skin and vulva look normal but sometimes there can be a degree of redness that is not an infection or skin problem.

Biopsy

Biopsy is not routinely recommended, even when the area looks red. Biopsy findings in women with symptoms have often been similar to women without symptoms.

How is it treated?

Most cases will eventually resolve without treatment, though this can take months or years.

Treatments include:

- **Local anaesthetic gel** - in very mild cases this may be sufficient. Unless there is irritation, the usual prescription is 2% lignocaine gel 3-5 times daily at the vaginal opening only, for up to 3 months. If tolerated, a 5% lignocaine ointment can be used for the second and third months.
- **Pelvic floor muscle retraining** with biofeedback techniques is the single most helpful treatment. A referral to a specialist women's health physiotherapist should be made. Women are usually unaware of chronic tension in their pelvic floor, as well as in their abdomen and upper legs. Physiotherapy will help to 'downtrain' these muscles. Later, vaginal 'downtrainers' of graduated sizes are used under the guidance of the physiotherapist, to release the tone and action of the muscles. They are not used to stretch the vagina, as the elasticity of the tissues will be normal.

- **Change in sexual practices**. We often suggest no intercourse until both partners have an understanding of vulvodynia and improvements begin. Otherwise there is a risk of prolonging the symptoms from repeated anticipation and experience of pain. However, if comfortable, agree to limit the amount of time that vulval and vaginal touch lasts. There needs to be enough sensual touch to feel aroused and you should feel able and confident to give a clear indication on whether to proceed or stop. Talk about this with your partner and agree beforehand whether sexual penetration will occur and when to stop.
- **Cortisone ointment** - a mild cortisone ointment may help if there is an associated dermatitis.
- **Candida treatment** - a trial of candida treatment for at least 2 months may help if chronic thrush is suspected. Sometimes the diagnosis of subtle chronic candida is difficult and tests can be negative.
- **Neuromodulating medications**. Low dose tricyclic antidepressants and the anticonvulsants pregabalin and gabapentin can be very effective, combined with physiotherapy and counselling. These medications adjust pain perception, rather than treat depression. The dose used is NOT an effective antidepressant. If significant depression is present, this should be treated on its merits. However, sleep and anxiety may be improved with the low dose and this itself will help pain.
- **Counselling for the impact of pain**. A woman and her partner's responses to her pain is very important to assess. It is natural and common to be significantly affected by the symptoms. Partners often have different knowledge and fears about the implications of longstanding symptoms. Counselling both alone and together can be very helpful.
- **Surgery**. Very occasionally surgical removal of an isolated tender area can be very successful. Widespread areas of pain are not suitable for surgery. Referrals are made to highly skilled gynaecologists and a very thin portion of the tender area is removed and covered over with a small section of the back vaginal wall. It is often difficult to visually detect the surgery after healing.

There is no strong evidence to support the role of particular diets in treating vulvodynia.

Are there any complications if not treated?

Anxiety and depression are common consequences of any chronic painful condition. Pre-existing stressors, fear of the anticipated pain, consequent poor arousal and poor lubrication may worsen the experience of pain. Sexual relationships invariably suffer even when both partners have a good understanding of the condition and are mutually supportive.

Professional counsellors are often very helpful in sorting through these natural reactions, and they help to find an effective way of expressing some of the inevitable frustrations most partners feel.

Where can I get help?

- Visit a sexual health service near you
- Visit your local doctor