MSHC
MELBOURNE SEXUAL HEALTH CENTRE

Vulvodynia treatment guidelines

Also known as vestibulitis, provoked vulvodynia (PVD), localised provoked vulvodynia (LPV), localised provoked vestibulodynia, spontaneous generalised vulvodynia

Vulvodynia is a well-recognised chronic pain condition.

Types

The International Society for the Study of Vulvovaginal Disease (ISSVD) defines vulvodynia as vulvar pain of at least 3 months duration, without a clear, identifiable cause and which may have potential associated factors.

There are two types of vulvodynia. The two types of vulvodynia can overlap and patients can experience symptoms of both.

1. Localised provoked vulvodynia (LPV). Also known as Provoked vulvodynia (PVD) and previously known as vestibulitis:
    - Typically felt at the vaginal opening
    - Triggered by vaginal penetration or touch
    - May be experienced with clitoral touch (clitorodynia)
2. Spontaneous generalised vulvodynia
    - Discomfort or pain felt anywhere on the vulva, may not be associated with sexual pain
    - Usually has a variable pattern and difficult for the patient to describe nature (often burning or raw or both) and location

Causes

Vulvodynia is a diagnosis of exclusion and is a dysfunctional pain disorder.

Dysfunctional pain can be associated with pathological pain of known aetiology.

Pelvic floor muscle (PFM) overactivity, often known as vaginismus, is typical in provoked vulvodynia.

Pain associated with sexual activity is common.

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.

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

Clinical presentation

Any vulval pain may be:

- due to a known cause or pathology – expect skin or investigation abnormalities, or
- dysfunctional (vulvodynia) – expect to see normal skin and mucosa, including variable usually symmetrical redness

Diagnosis

A diagnosis of vulvodynia is largely based on history.

Examination and investigations are necessary to exclude other conditions and treat associated conditions.

Uncomplicated provoked vulvodynia

- Skin and anatomy look normal
- No history or investigations to suggest candida or HSV
- Typical history – mild-moderate pain provoked by any penetration or pressure rom items such as tampon, fingers, intercourse or tight clothing
- No symptoms if not touched
- Patient may describe a feeling of “afterburn” following touch, pressure, penetration or examination
- Typical cotton tip discomfort: Provoked - maximal at 5 and 7 o’clock in vestibule, and usually PV cotton tip discomfort (without speculum)
- Introitus looks tight or 'sucked' in can be indication of pelvic floor muscle overactivity, and tenderness with fingertip palpation laterally mid to low vagina

Complicated provoked vulvodynia

- Severe and long duration of pain
- Associated chronic dermatitis, lesions, candida or lichen planus
- Other associated chronic pain conditions such as chronic bladder pain, irritable bowel syndrome, migraine, TMJ pain, fibromyalgia, back pain
- Associated PTSD, especially childhood and sexual abuse and fear of pain
- Anxiety and depression

Spontaneous generalised vulvodynia

- Skin and anatomy look normal
- Less common than provoked vulvodynia
- Tends to occur in older women
- Discomfort in the absence of touch or pressure
- Variable discomfort with gentle touch, affecting part or all of the vulva
- Can complicate provoked vulvodynia (mixed pattern)

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

Management

Provide patient with Melbourne Sexual Health Centre fact sheet on vulvodynia.

Suggest patient:

- discusses pain with her partner

- shares educational material
- avoids any sexual practice that triggers pain until a strategy is decided on. Otherwise the cycle of fear and more pelvic floor muscle overactivity reinforces the pain.

Refer patient to counselling service regarding the impact of pain. Normalise that there will be an impact on both partners.

Recommended	Comments
Dermatitis treatment if needed	MSHC fact sheet on genital skin care provides useful information
Candida treatment	6-8 weeks of suppressive fluconazole if uncertain whether recurrent/chronic candida is a trigger
Herpes Simplex Virus suppression	If history is suggestive of HSV
Local anaesthetic gel	If the woman can touch her vulva: 2% xylocaine gel 2-3 times a day to the introital area (to aid desensitisation), up to 3 months, and massage the vestibule/PFMs at same time with her fingertip. Xylocaine commonly has an initial burn that settles quickly
Referral to pelvic floor physiotherapist	Continence Foundation of Australia for Women's Health Physiotherapists
Pelvic floor muscle re-training	Pelvic floor muscle re-training 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. If comfortable, patient and partner can negotiate limits around the amount of time that vulval and vaginal touch lasts and whether sexual penetration will occur and when to stop.
Cortisone ointment	If there is an associated dermatitis a mild cortisone ointment may help
Candida treatment	If chronic thrush is suspected a trial of candida treatment for at least 2 months may help . 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's 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.

Recommended	Comments
The role of 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.

References

It is important for patients and partners to have a good understanding of the drivers of pain and chronic pain theory.

1. www.vulvovaginaldisorders.org An algorithm for basic adult diagnosis and treatment
2. www.noigroup.com is the best chronic pain website for patients and practitioners.
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5. Alicia M Thornton and Catherine Drummond. Current concepts in vulvodynia with a focus on pathogenesis and pain mechanisms. Australasian Journal of Dermatology (2016) 57, 253–263