Pelvic Floor Physical Therapy for Vulvodynia

A Clinician's Guide

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KEYWORDS

• Vulvodynia • Vestibulodynia • Dyspareunia • Pelvic floor dysfunction
• Pelvic floor physical therapy

KEY POINTS

- Most women with complaints of vulvar pain have pelvic floor dysfunction.
- Pelvic floor screenings can be easily incorporated into a gynecology examination to identify pelvic floor dysfunction.
- Successful treatment plans for vulvodynia are multimodal and include pelvic floor physical therapy.

INTRODUCTION OF NEW NOMENCLATURE

In 2003, the International Society for the Study of Vulvovaginal Disease (ISSVD) defined vulvodynia as 'vulvar discomfort, most often described as burning pain, occurring in the absence of relevant visible findings or a specific, clinically identifiable, neurologic disorder'. This terminology served to acknowledge vulvar pain as a real disorder but fell short of classifying the syndrome as anything more than idiopathic pain. At that time, little was known about the pathophysiologic mechanisms that cause vulvodynia and treatment options were limited. Over the past decade, researchers have identified several causes of vulvodynia as well as associated factors/impairments. This identification resulted in the need to develop a new classification system to guide physicians toward better diagnosis and treatment. Last year the ISSVD, the International Society for the Study of Women's Sexual Health, and the International Pelvic Pain Society came together to review the evidence and publish the 2015 Consensus Terminology and Classification of Persistent Vulvar Pain and Vulvodynia. Individuals from the American College of Obstetrics and Gynecology, American Society for Colposcopy and Cervical Pathology, and the National Vulvodynia Society also participated.[1]

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The 3 societies reviewed the evidence and determined that persistent vulvar pain caused by a specific disorder can be categorized into 7 different groups, with vulvodynia as a distinct separate entity of vulvar pain not caused by a specific disorder (**Box 1**). In addition, 8 factors/impairments were shown to be associated with vulvodynia, though the research does not yet support if these factors are a cause or an effect (**Box 2**). The final consensus and conclusion was that "vulvodynia is not one disease but a constellation of symptoms of several (sometimes overlapping) disease processes, which will benefit best from a range of treatments based on individual presentations." Although each case of vulvodynia is different, there is one underlying common component in these women that can cause significant pain and functional limitations: the pelvic floor muscles, which are the focus of this article.

PREVALENCE OF MUSCULOSKELETAL IMPAIRMENTS IN WOMEN WITH VULVODYNIA

When clinicians think of pelvic floor disorders, low-tone disorders associated with stress urinary incontinence, pelvic organ prolapse, the peripartum period, and menopause often come to mind. The treatment solution is often saying *do your Kegels*. Over the past 2 decades, numerous, repeated studies have concluded that high-tone or hypertonic pelvic floor muscles are associated with pelvic pain disorders and dyspareunia, including vulvodynia.[2–5] Although it may be less common to think of high-tone or overactive pelvic floor disorders, these disorders affect roughly 16% of women. Currently it is estimated that 10 million women have chronic pelvic pain; less than 70% will receive a proper diagnosis, and 61% will remain undiagnosed.[5] Reissing and colleagues[6] reported that 90% of women diagnosed with provoked vestibulodynia demonstrated pelvic floor dysfunction. In 2015, Witzeman and colleagues[7–9] conducted a proof-of-concept study to determine mucosal versus muscle pain sensitivity in women with provoked vestibulodynia. They concluded mucosal measures alone may not sufficiently capture the spectrum of the clinical pain report

Box 1
2015 Consensus terminology and classification of persistent vulvar pain and vulvodynia

A. Vulvar pain caused by a specific disorder[a]
   a. Infectious (eg, recurrent candidiasis, herpes)
   b. Inflammatory (eg, lichen sclerosus, lichen planus, immunobullous disorders)
   c. Neoplastic (eg, Paget disease, squamous cell carcinoma)
   d. Neurologic (eg, postherpetic neuralgia, nerve compression or nerve injury, neuroma)
   e. Trauma (eg, female genital cutting, obstetric)
   f. Iatrogenic (eg, postoperative, chemotherapy, radiation)
   g. Hormonal deficiencies (eg, genitourinary syndrome of menopause [vulvovaginal atrophy], lactational amenorrhea)

B. Vulvodynia: vulvar pain of at least 3 months' duration, without a clear identifiable cause, which may have potential associated factors; The following are the descriptors:
   a. Localized (eg, vestibulodynia, clitorodynia) or generalized or mixed (localized and generalized)
   b. Provoked (eg, insertional, contact) or spontaneous or mixed (provoked and spontaneous)
   c. Onset (primary or secondary)
   d. Temporal pattern (intermittent, persistent, constant, immediate, delayed)

[a]Women may have both a specific disorder (eg, lichen sclerosis) and vulvodynia.

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