Vulval pain

Emily Lord

Annabel Forsythe

Anne Edwards

Abstract

Vulval pain is an uncommon and poorly recognized condition, with women often seeking help from several different clinicians before the diagnosis is made. It should be considered within the differential diagnosis in a number of gynaecological presentations, including superficial dyspareunia, apparent persistent/recurrent candidiasis and chronic vulval symptoms such as discomfort and itch. The aetiology is poorly understood, and the approach to treatment is often inconsistent and not based on established, evidence-based practice guidelines. Although most patients recover, there is no doubt that, for some, vulval pain can impact significantly on their quality of life, adversely affecting relationships and activities of daily living. Early diagnosis and a multidisciplinary approach may improve the prospects of recovery.

Keywords Dyspareunia; generalized vulval dysaesthesia; localized vulval dysaesthesia; MRCP; vaginismus; vulval pain syndrome; vulvodynia

Key points

- Consider vulval pain syndrome (VPS) in any woman presenting with a long history of pain, itch, irritation or a history of recurrent *Candida albicans* that does not respond to treatment
- VPS is a diagnosis of exclusion
- The aetiology of VPS is poorly understood
- VPS can coexist with other dermatological or infective conditions
- VPS may require a multidisciplinary approach to management
- The mainstay of pharmacological therapy is tricyclic antidepressants for their analgesic effects. Other medications may be tried if these are ineffective or patients are intolerant of them

Introduction

Vulvodynia, or vulval pain syndrome (VPS), is a poorly understood, yet increasingly well recognized, condition in the developed world. A significant proportion of women consult multiple physicians, undergoing numerous investigations and uncorroborated treatments before diagnosis.[1] Inadequate, inappropriate or delayed treatment can cause psychological distress, further impair relationships and adversely affect many aspects of a patient's life.[2]

Definition

The International Society for the Study of Vulvovaginal Disease defines chronic VPS as 'vulval discomfort, most often described as burning pain, occurring in the absence of relevant visible findings'. It is thought to be a constellation of symptoms of several (often overlapping) disease processes (Table 1).[3]

Emily Lord *MB ChB BSc DipGUM DipHIV is a Locum Consultant working in Oxford Sexual Health, UK. Competing interests: none declared.*

Annabel Forsythe *MB ChB DipGUM is a Community Sexual and Reproductive Health Specialist Trainee working in Oxford Sexual Health, UK. Competing interests: none declared.*

Anne Edwards *MA BM BCh FRCP is a Consultant in Genitourinary Medicine, Oxford Sexual Health Service and Honorary Senior Lecturer at the Nuffield Department of Medicine and Fellow, Brasenose College, Oxford University, UK. Competing interests: none declared.*

Epidemiology

The lifetime prevalence of VPS may be as high as 16–28% of women.[4] In a sexual health service with a total of 4000 new female attendances per annum, a specialist vulval clinic will expect to see two or three new cases of vulval pain per week.

Onset typically occurs between the ages of 18 and 25 years. The most common presentation is localized provoked VPS, especially in premenopausal women. It can include the clitoris (clitorodynia) and/or the vulval vestibule (vestibulodynia). Generalized VPS is more common in peri- and postmenopausal women.[4]

VPS can be associated with other chronic pain syndromes, such as fibromyalgia, interstitial cystitis or chronic fatigue.[1] There is evidence to suggest that women with depression or anxiety are more likely to suffer VPS, but there is no evidence for a primary psychological cause for the pain.[5]

Pathology and pathogenesis

Although many theories have been proposed to explain the aetiology of VPS (Table 2), there is no consensus regarding the precise cause and it is believed to be multifactorial.[4]

Course of the disease

Patients can present with primary VPS, experiencing pain from the onset of any vaginal penetration or touch (e.g. attempting to use tampons), or secondary symptoms, presenting after previously being pain-free. VPS can follow a relapsing and remitting course. Most patients improve and/or fully recover with time. One study by Reed et al. (see Further reading) has shown that 51% of patients' experience complete remission over 6–30 months. However, around 10% have intractable disease with no treatment being effective.

Diagnosis

History

VPS is a diagnosis based on a typical history, which can sometimes stretch over several years, combined with a normal vulval

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2015 consensus terminology and classification of VPS

Vulval pain caused by a specific disorder[a]

- Infection (e.g. recurrent *Candida albicans*, herpes simplex virus)
- Inflammation (e.g. lichen sclerosus, lichen planus, immunobullous disorders)
- Neoplasm (e.g. Paget's disease, squamous cell carcinoma)
- Neurological (e.g. post-herpetic neuralgia [rare in HSV infection], nerve compression or injury)
- Trauma (e.g. female genital cutting, obstetrics)
- Iatrogenic (e.g. postoperative, chemotherapy, radiation)
- Hormonal (e.g. menopause [vulvovaginal atrophy], lactational amenorrhoea)

Vulval pain of at least 3 months' duration, without a clearly identifiable cause, which can have potential associated factors

The following are the descriptors:

- Localized (e.g. vestibulodynia, clitorodynia) or generalized or mixed
- Provoked (e.g. contact), spontaneous or mixed
- Onset (primary or secondary)
- Temporal pattern (intermittent, persistent, constant, immediate, delayed)

[a] Women can have both a specific disorder (e.g. lichen sclerosus) and vulvodynia.

Table 1

Proposed aetiological mechanisms for developing VPS

Neurological proliferation and sensitization	Peripheral sensitization occurs secondary to inflammatory conditions, which in turn leads to abnormal, persistent stimulation of central nociceptors
Infection	Patients may report that their VPS started after a bad episode of *Candida albicans* infection. However, it is difficult to establish whether an inflammatory event triggered the VPS or it was a coincidental temporal association
Genetic factors	Genetic polymorphisms (e.g. interleukin-1β) may impair the immune system response to trauma or infection, decrease the ability to terminate inflammation or increase susceptibility to pain
Hormonal factors	A possible correlation to VPS and hormonal contraception use has been made, especially in compounds with <20 micrograms ethinylestradiol
Pelvic floor dysfunction	Pelvic floor muscle dysfunction can worsen VPS, and pelvic floor hypertonus can develop in women with VPS — touch triggers a reflex contraction in the pelvic floor muscles (secondary vaginismus)

Table 2

appearance on examination. A detailed pain history is important to assess the degree of symptoms and the impact on the patient (Table 3). Identification of sexual dysfunction is important as psychosexual counselling may be a helpful complement to medical therapy.[5]

Examination

The vulva usually looks normal, but should be inspected for underlying conditions. A cotton bud is gently applied to the vulva in the interlabial sulci, at the introitus and around the clitoris to check for pain sensation (allodynia). In generalized VPS, touching the affected area does not trigger or worsen symptoms. In localized VPS, patients are symptom-free until the vulva is touched. The distribution can be asymmetrical. If tolerated, digital palpation of the levator muscles is useful to assess muscle symmetry and hypertonicity.[2]

Investigations

As this is a diagnosis of exclusion, there are no specific investigations for confirming VPS. It is, however, essential to exclude other causes, for example by microscopy and culture for *Candida albicans* in patients with relapsing and remitting symptoms. If the clinical examination is normal, a biopsy is not indicated. If the examination is not normal, other disorders should be diagnosed and managed before making a diagnosis of VPS. Although an underlying neurological disorder is rare, a neurological examination should be performed if there are symptoms or signs suggestive of focal neurology.

Differential diagnosis

Although VPS is a diagnosis of exclusion, a full history and thorough examination of the mouth, genitalia and skin should rule out other diagnoses (Table 1). Other specific conditions to consider include recurrent hymenal or posterior fourchette tears (examine the woman within 48 hours of intercourse if this is suspected) and symptomatic dermographism. Pudendal neuralgia, an entrapment nerve syndrome, can present with symptoms similar to vulval pain; however, patients usually experience pain on sitting, which is relieved by standing or lying, and they can have a sensation of fullness in the vagina.[2,5]

Management

The limited understanding of the aetiology of VPS has led to a lack of consistent treatment strategies.[1] It is therefore difficult to establish evidence-based practice guidelines as current strategies follow a 'trial and error' approach, guided mainly by expert opinion rather than randomized clinical trials.

An initial explanation of the diagnosis and the lack of underlying serious pathology can allay fears and be reassuring. Simple measures such as avoiding potential vulval irritants, wearing exclusively cotton underwear and avoiding tight clothing may help.[5]

Topical therapies

Topical agents, such as moisturizing creams and corticosteroids, can be soothing but rarely produce sustained improvements. A trial of a local anaesthetic agent (e.g. 5% lidocaine ointment) can be considered.[4,5] This can be particularly helpful in women with provoked VPS if applied 15–20 minutes or so before sexual

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