Vulvodynia

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Abstract

Vulvodynia is neuropathic pain of at least 3 months' duration which has recognised associated factors, the underlying cause of the condition is unclear. There are published guidelines for the management of vulvodynia, which recognise that multidisciplinary input is required for its successful treatment. There are also good resources that can be accessed online by women experiencing vulvodynia and clinicians coordinating their care.

Keywords neuropathic pain; vulval pain; vulvodynia

Vulvodynia is vulval pain of at least 3 months' duration without clear identifiable cause, which may have potential associated factors. It occurs in women of all ages and impacts on physical, mental, emotional and sexual well-being. Although there are associated factors the cause of vulvodynia is poorly understood. It is thought to be neuropathic pain and successful treatment strategies are often multifaceted and multidisciplinary.

The 2015 International Society for the Study of Vulval Diseases (ISSVD), International Society for the Study of Women's Sexual Health (ISSWSH) and International pelvic pain society (IPPS) Consensus terminology and classification of persistent vulvar pain differentiated vulvar pain with a specific cause eg infectious, inflammatory, neoplastic, traumatic, iatrogenic and hormonal from vulvodynia, pain that does not have a clearly identifiable cause (Box 1). It recognised descriptors of site as; localised, generalised or mixed; patterns of provocation – provoked or spontaneous or mixed; onset as primary or secondary and temporal patterns as intermittent, persistent, constant, immediate or delayed.

A footnote to the classification recognises that vulvodynia can coexist with other vulval conditions.

The consensus terminology lists potential factors associated with vulvodynia one or more of which may be relevant for any individual patient and may form treatment targets (Box 2). These potential factors reflect evidence collated from a large number of studies trying to identify causes of vulvodynia over recent years.

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2015 Consensus terminology and classification of persistent vulvar pain and vulvodynia

A. Vulvar pain caused by a specific disorder
- Infectious (eg, recurrent candidiasis, herpes)
- Inflammatory (eg, lichen sclerosus, lichen planus, immunobullous disorders)
- Neoplastic (eg, Paget's disease, squamous cell carcinoma)
- Neurologic (eg postherpetic neuralgia, nerve compression or injury, neuroma)
- Trauma (eg, female cutting, obstetrical)
- Iatrogenic (eg postoperative, chemotherapy, radiation)
- Hormonal deficiencies (eg genitourinary syndrome of menopause [vulvovaginal atrophy], lactational amenorrhoea)

B. Vulvodynia-vulvar pain of at least 3 months' duration, without clear identifiable cause, which may have potential associated factors.

The following are the descriptors:
- Localised (eg vestibulodynia, clitorodynia) or generalised or mixed (localised and generalised)
- Provoked (eg, insertional, contact) or spontaneous or mixed (provoked and spontaneous)
- Onset (primary or secondary)
- Temporal pattern (intermittent, persistent, constant, immediate, delayed)

Box 1

The current British guidance from the British Society for the Study of Vulval Disorders (BSSVD) was published in 2010 (Box 3). It offers 12 recommendations on diagnosis and management. These recommendations are of evidence levels B and C.

History

The BSSVD guidance recommends obtaining a detailed pain history that may involve the use of standardised pain assessment tools (e.g. the McGill Questionnaire). In addition where appropriate a sexual history should be obtained.

Potential factors associated with vulvodynia

- Co-morbidities and other pain syndromes (e.g. painful bladder syndrome, fibromyalgia, irritable bowel syndrome, temporomandibular disorder)
- Genetics
- Hormonal factors (e.g. pharmacologically induced)
- Inflammation
- Musculoskeletal (e.g. pelvic muscle overactivity, myofascial, biomechanical)
- Neurologic mechanisms: Central (spine, brain), Peripheral
- Neuroproliferation
- Psychosocial factors (e.g. mood, interpersonal, coping, role, sexual function)
- Structural defects (e.g. perineal descent)

Box 2

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Summary of BSSVD recommendations 2010

1. An adequate pain history should be taken to assess the degree of symptoms and the impact on the woman. The clinician should categorize which subgroup of vulvodynia the patient has according to the ISSVD definitions (Box 1).
2. If appropriate patients with sexual pain (dyspareunia) should have a sexual history taken to identify sexual dysfunction
3. The diagnosis of vulvodynia is clinical
4. A team approach may be necessary to address the different components of vulvodynia. A lead clinician should triage patients and consider referral to other health professionals who have a role in vulvodynia management, e.g. psychosexual medicine, physiotherapy, pain management teams
5. Combining treatments should be encouraged
6. Patients should be given an adequate explanation of their diagnosis, relevant written information and suggested contact information. When prescribing treatments clear instruction should be given on how to take medication
7. Topical agents should be used with caution to avoid the problem of irritancy. A trial of local anaesthetic agent may be considered in all vulvodynia subsets
8. Tricyclic antidepressant drugs (TCAs), e.g. amitriptyline or nortriptyline, are an appropriate initial treatment for unprovoked vulvodynia. Other drugs may be considered including gabapentin and pregabalin which can be given in addition to a TCA
9. Surgical excision of the vestibule may be considered in patients with local provoked vulvodynia (vestibulodynia) after other measures have been tried. Only a minority of patients may be suitable for surgery. If surgery is offered, adequate counselling and support should be given to the patient both pre- and postoperatively
10. Pelvic floor muscle dysfunction should be addressed in patients with vulvodynia who have sex-related pain. Techniques to desensitize the pelvic floor muscles are likely to be beneficial
11. Acupuncture may be considered in the treatment of unprovoked vulvodynia
12. Intralesional injections local anaesthetic with corticosteroid may be considered in patients with provoked vulvodynia

Box 3

The pain of vulvodynia is typically described as a burning sensation and is frequently exacerbated by tight clothing or prolonged episodes of sitting or intercourse. Itch is not usually a prominent feature and if present can point to an underlying skin condition.

In young women presenting with vulval pain there is often a clear history of recurrent candida infection.

It is not unusual that the woman has had multiple consultations with doctors of different specialities and may have had a variety of topical and systemic treatments.

The woman may suffer from other chronic pain syndromes such as fibromyalgia, painful bladder syndrome, IBS or migraine.

On presentation the woman may have identified stress as an exacerbating factor in her vulval symptoms and sexual or relationship problems may have developed.

Physical examination

Physical examination is essential to rule out an underlying skin condition and vulval biopsy may be necessary if skin changes are subtle.

A q tip test (using gentle pressure on the vulva with a cotton bud to localise pain) is useful in identifying the area of pain which is frequently at the 5 and 7 o'clock positions at the introitus but may localise to any area of the vulva.

Some erythema may be noted at the vestibule but this is not a consistent finding.

A vaginal examination may reveal tension in the pelvic floor musculature which may have precipitated the pain or which may have developed as a secondary phenomenon. Specific trigger points may be identifiable which can be treated with physiotherapy.

Diagnosis is made on exclusion of other vulval skin conditions (bearing in mind that vulvodynia can co-exist with other conditions) through typical history and examination findings.

Treatment

Many women presenting with vulvodynia express the feeling that their condition and its unpredictable nature has taken over their lives and they feel powerless to control their symptoms. The focus of treatment is to arm the woman with one or more strategies which can be called upon when her symptoms flare up and put her firmly back in control of her life and her condition.

Often more than one treatment approach is required to alleviate symptoms and it is desirable to let the woman select her preferred treatment strategy from those locally available once they have been outlined to her in a shared decision making process.

It is essential for a vulval service to be part of a network of clinicians who can offer different treatment approaches to ensure that full range of treatment strategies that are known to be helpful are available. Women are triaged to the most appropriate service eg physiotherapy, pain management, clinical psychology and sexual therapy from the vulval clinic. The BSSVD published standards on the care of women with vulval conditions in 2013 and this described a vulval service as having core and extended members from a wide variety of disciplines and specialities.

An explanation of neuropathic pain should be given to the woman along with reassurance of the absence of pathology within the vulval skin itself. The British Association of Dermatologists excellent patient information sheet on vulvodynia can be printed directly from their website http://www.bad.org.uk/for-the-public/patient-information-leaflets and is a useful resource to provide, the leaflet also signposts other sources of information that the woman may wish to explore.

General vulval skin care measures

Avoidance of any potential irritants including perfumed products is an important first line in management. Appropriate wash products such as any product designed for eczema sufferers should be advised along with an emollient/barrier preparation. Hydromol ointment works well as both a wash product and vulval moisturiser as does emulsifying ointment. Aqueous cream can be recommended as a wash product but should not be left on

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