Management of Vulval Pain

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Pain

“An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.”

(IASP, 1979)

“What a patient says hurts.”

(McCaffery, 1988)
Physiology of Pain

Transduction
Nociceptive stimulus
Peripheral sensitisation
C
Ad
Ab

Neuronal transmission
Nerve impulse
Spinal cord
Central modulation wind up & central sensitisation

Higher centre activation
Descending inhibition
Referral Pathways:

- Complementary Therapies
- Patient
- Private Sector
- Internet Support Groups
- Dermatologist
- Gynaecologist
- Urologist
- Gastroenterologist
- GI Surgeons
- Orthopaedic Surgeon
- Pain Clinic
- PPC
Definition of vulvodynia:

- Vulval discomfort (often burning) in the absence of relevant visible findings or specific clinically identified neurological disorder
### Classification:

<table>
<thead>
<tr>
<th>ANATOMY</th>
<th>PATHOPHYSIOLOGY</th>
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</thead>
<tbody>
<tr>
<td>Focal vulvodynia</td>
<td>Provoked</td>
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<tr>
<td>Generalised vulvodynia</td>
<td>Unprovoked</td>
</tr>
<tr>
<td>Hemi-vulvodynia</td>
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<tr>
<td>Clitorodynia</td>
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</table>
Onset and initial findings:

- Most prevalence between 18 and 25 years but 4% between 45 -54 years and another 4% aged 55-64 years

- Seven times more likely to report difficulty and pain with first tampon use

- Evaluate hymen and the levator ani

- 50% the pain limited sexual intercourse
### Associated features:

<table>
<thead>
<tr>
<th>MEDICAL</th>
<th>SEXUAL</th>
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<tbody>
<tr>
<td>Candida infection</td>
<td>Dyspareunia</td>
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<tr>
<td>Vulvar dystrophies</td>
<td>Loss of libido</td>
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<tr>
<td>Neoplasms</td>
<td>Vaginal dryness</td>
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<tr>
<td>Contact dermatitis</td>
<td>Orgasmic difficulty</td>
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<tr>
<td>Hormonally induced atrophy</td>
<td>Sexual aversion</td>
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<tr>
<td>Painful bladder syndrome</td>
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<tr>
<td>Endometriosis</td>
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<tr>
<td>Irritable bowel syndrome</td>
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<tr>
<td>Fibromyalgia</td>
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<tr>
<td>Headache</td>
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<tr>
<td>Pudendal neuropathy, MS</td>
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<tr>
<td>MSK referred pain</td>
<td></td>
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<tr>
<td>Surgery</td>
<td></td>
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<tr>
<td>Radiotherapy</td>
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</tbody>
</table>

+ MSK referred pain
Impact of vulvodynia:

- PHYSICAL:
- PSYCHOSEXUAL:
- SOCIETAL
Chronic pain consultation:

- CHRONIC PAIN MANAGEMENT

- CHRONOLOGICAL ASPECTS
- EXAMINATION / INVESTIGATIONS
- OBSTACLES TO RECOVERY
- CONTRACT
- PAIN HISTORY
- PAST MEDICAL HISTORY
- FAMILY HISTORY
- PSYCHOLOGICAL ASPECTS
- SOCIAL ASPECTS
- SEXUAL ASPECTS
- BELIEFS & EXPECTATIONS
- ACTIVITIES OF DAILY LIVING
- QUALITY OF LIFE / GOALS
- "DRUGS" HISTORY
- FINANCIAL ASPECTS
- WORK ASPECT
- LEGAL ASPECTS

SOURCE OF REFERRAL
Individual Variation

VULVODYNIA

Psychological Impact
- Depression/Anxiety
- Loss of Esteem
- Psychiatric Illness

Sexual
- Libido
- Arousal
- Orgasm

Functional
- Occupation
- Finances
- Societal

Psychological Predisposition
- History
- Personality
- Tolerance
Targeted physical examination:

* burning, irritation, stinging, raw feeling, crawling or pain down there *

But no itching!

- Vulvar examination:

- Pelvic floor evaluation:

- Vaginal inspection:
Investigations:
Differential diagnosis:
CAUTION:
Every therapy works sometime of the time for some of the people!
Therapeutic Choices

- Bio-medical v Bio-psycho-social approach

- Surgery

- Nerve blocks

- Psychology

- Drugs

- Physiotherapy

- Non-Drug

Increasing complexity, costs and benefits
Non-Drugs

- Explanation
- Reassurance
- Cling Film
- Heat/Cold
- Massage
- Pressure
- Vibration
- Exercise
- Physiotherapy
- TENS
- Mirrors
- Education
- Peer Support Groups
- Relaxation
- Imagery
- Distraction
- Psychotherapy
- Hypnosis
- Counselling
- Biofeedback
- Prayer
Drugs

- NSAID/Coxib
- LA
- Steroids
- Opioids
- Adjuvants:
  - Anti-Depressants
  - Anti-Convulsants

WHO 3-Step Ladder

1 mild
- Aspirin
- Acetaminophen
- NSAIDs
  ± Adjuvants

2 moderate
- APAP/Codeine
- APAP/Hydrocodone
- APAP/Oxycodone
- APAP/Dihydrocodeine
- Tramadol
  ± Adjuvants

3 severe
- Morphine
- Hydromorphone
- Methadone
- Levorphanol
- Fentanyl
- Oxycodone
  ± Adjuvants

Opioids

Tolerance - Chronic use leads to decline in potency
Dependence – Physiological “cold turkey”
Addiction – Sociopathic or criminal behaviour

**Problems**

1. Respiratory Depression
2. Constipation
3. Endocrine dysfunction
4. Itch
5. Cognitive dysfunction
6. Reduction in immunity

**Types**
- Codeine
- Tramadol
- Morphine
- Oxycodone
- Fentanyl
- Buprenorphine
- Tapentadol
Treatment of vulvodynia:

- Reduction of triggers and irritating stimuli
- Reduction in pain
- Treating pelvic floor dysfunction
- Treating psychosexual ramifications
Reduction of triggers:

- Avoid vulval irritants
- Adequate water soluble lubrication for intercourse
- Apply ice pack, rinse with cool water post coitus
- All white cotton underwear
- Loose fitting clothes
- Use approved intimate detergents
- Use soft white unscented toilet paper
- Avoid shampoo
- Avoid scented soaps
- Prevent constipation
- Avoid exercises that put direct pressure or friction
- Use 100% cotton tampons
Reduction of pain:

- Topical lidocaine ointment/gel
- Topical estradiol
- TENS
- TCA
- SNRI
- Gabapentin/Pregabalin
- Trigger point injection
- Pudendal nerve block
- Vestibulectomy

Start low, go slow and don’t stop abruptly!
Treatment of pelvic floor dysfunction:

- Pelvic floor exercises
- External/internal soft tissue self massage
- Trigger point pressure
- Biofeedback
- Use of vaginal trainers/dilators
Treatment of psychosexual ramifications:

- Counselling
- Sex therapy
- Cognitive – behavioural therapy
- Psychotherapy
Invasive techniques:

LOCAL ANAESTHETIC + STEROID INFILTRATION:
PUDENDAL NERVE BLOCK:
OTHER BLOCKS:

1. Take an adequate history
2. Take a sexual history if there is dyspareunia
3. Diagnosis is a clinical one
4. Take an MultiDisciplinaryTeam (MDT) approach
5. Combine treatments
6. Give an adequate explanation
7. Caution with topical agents
8. Nortriptyline/Amitriptyline +/- Gabapentin/Pregabalin
9. Surgical excision is sometimes indicated
10. Identify pelvic floor dysfunction if there is sex related pain
11. Acupuncture is unproven but may help some patients
12. Injections may help
So Why is Pain Control Difficult?

- Time & expertise (education)
- Managing expectations
- Co-existent morbidity
- Concurrent medications/analgesics/allergies/drug side effects and interactions
- Age related changes
- Individual response to pain
- Difficulties in assessing pain
- Cognitive impairment
- Opiophobia
- Costs
- Poor attitude to suffering
- Cultural factors
Conclusion:

- Vulval pain is commoner than we think
- Strive for a multidisciplinary approach
- Don’t go looking for a cure; concentrate on function
- Pain and suffering are horrible twins!
Thank you for your attention!

Acknowledgement to patients and colleagues for all their contributions to our Pelvic Pain Service at UHSM.