Vulval Pain – present knowledge
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Vulval symptoms

• Itch (Pruritus)
• Pain
• Lump/lesion

‘Not all itching is due to thrush, not all pain is psychosomatic’
How do women present?

- Multiple visits to GP
- Often recurrent courses of anti fungal medication
- Internet searches
- Psychosexual counselling
- Relate
- Dermatology
- General Gynaecology
- GUM
- Etc etc etc
Common complaints

• Pain at intercourse (dyspareunia)
• Entry pain, can be experienced with tampons
• Characteristically ‘burning, raw, splitting’ sensation
• Prolonged discomfort after intercourse
• Constant burning around vulva, intercourse may be unaffected
• Mixed vulval and ‘cystitis-like’ pain
Complications

• Increasing difficulty leads to no intercourse
• Stress
• Relationship damage
• Loss of sexuality
• Depression
• Anger – with healthcare professionals, self, partner etc etc
• ? Impact on partners
Vulval infections and infestations causing pain or pruritus

- Fungal – candida (thrush), different if affects vulva rather than vagina
- Bacterial – Bacterial vaginosis
- HSV – genital herpes
- Worms in children
- HIV – HIV related ulceration (rarely causes pain)

*Pain is not associated with HPV*
Vulval skin conditions causing pain (Dermatoses)

- Eczema, dermatitis – *pruritus* > *pain*
- Psoriasis – *pain* = *pruritus*
- Lichen simplex chronicus – *pruritus* >> *pain*
- Lichen sclerosus – *pruritus* > *pain*
- Lichen planus – *pain* > *pruritus*
Case history 1

• 68 year old woman
• 30 years of irritation and itching
• Increasing difficulty with penetration, no intercourse for ‘years’
• Recent problems with passing urine
• Treated for depression
• Told skin changes due to menopause, given vaginal oestrogen, unable to insert cream, sent to see counsellor
Lichen sclerosus

- Common condition
- Affects all age groups
- Loss of architecture
- Resorption of tissue
- Pallor
- Ecchymoses
- Fissures
- Dominant symptom itching but pain common
- Dyspareunia
- Burning with micturition
- Does not affect the vagina
Management of Lichen sclerosus

• Potent topical steroids:
  - (clobetasol/Dermovate)
• Regular application once or twice daily
• Symptom resolution
• Skin changes ‘reversed’ but architecture not restored
• Watch for steroid damage – very rare!
• Regular follow-up, 6 – 12 monthly
Neoplastic vulval conditions:

• Intraepithelial neoplasia (VIN)
• Paget’s disease
• Squamous cell carcinoma
• Malignant melanoma

• Rarely cause pain – VIN and Paget’s itching +++
VIN – high grade of usual type (VIN3)

- Varied appearance, can look like warts – if they don’t respond to treatment see a doctor!
- ‘White’, ‘Red’
- Unifocal
- Multifocal, associated HPV, younger age
- Pruritus ++
- ‘Field change’ -CIN, PIN, PAIN
- Untreated risk of progression to Ca 25%
Paget’s disease

- Older women
- Intense pruritus
- Associated with adenocarcinoma
- Wide surgical excision
- Central UK register, BSSVD, Professor MacLean
Vulval Pain Syndromes

- Poorly understood, not well managed, women often wait years before appropriate referral
- Clinically *not just* gynaecological
- ISSVD definitions inconsistent, 1991 first classification, latest 2003
- Pain *more than 3 months in duration*
ISSVD Classifications

1999
- Essential/dysaesthetic vulvodynia
- Vulvar vestibulitis syndrome
- Cyclical vulvodynia
- *Vestibular papillomatosis*
- Dermatoses
- Infection

2003 –
- Primary/secondary
- Provoked/unprovoked
- Anatomical site i.e. vestibulodynia, clitorodynia
Royal Free NHS Vulval Pain clinic April 2008- 2009, (weekly clinic, Gynaecologist, Physiotherapy, Psychosexual support, access to Dermatology, joint clinic access)

- 129 new patients referred with vulval pain as primary diagnosis in letter:
  - 57 secondary provoked vestibulodynia
  - 7 secondary unprovoked vulvodynia
  - 10 primary, provoked vestibulodynia
  - 16 mixed unprovoked and provoked
  - 36 Lichen sclerosus
  - 1 psoriasis
  - 2 Lichen planus
Characteristics of Vestibulodynia

- Burning, rawness, splitting, at introitus
- Young women, usually premenopausal
- Entry dyspareunia
- Burning sensation lasts after intercourse
- Vestibular erythema – redness in circumference of entrance
- Q-tip tenderness over vestibular glands, just outside hymen
- Secondary > primary
- Primary more difficult to treat
What is the etiology?

Psychosexual “triggers”
- sexual impairment
- anxiety
- depression
- previous trauma
- genetic factors
- others

Pain amplification

Physiological “triggers”
- infections
- treatments
- hormonal status
- immunological factors
- allergies
- genetic factors
- others

Multi-factorial

Nina Bohm-Starke, FIGO 2009
Treatment Vestibulodynia

• Define triggers e.g. bacterial vaginosis, candida
• Steroids e.g Trimovate, *perhaps treating underlying skin condition*
• Local anaesthetic gel. To desensitise
• **Biofeedback techniques, effect on levator muscles**
• **Pelvic floor physiotherapy**
• **Surgery – excision of Q-tip sensitive skin**
• Pregabalin, Amitriptyline etc
But...no consensus on standard treatment

- Surgery
- Medical treatment – pain management
- Behavioral treatment – CBT, hypnotherapy
- EMG-biofeedback for the pelvic-floor muscles
- Others; botox – no evidence
- Multi-disciplinary approach

Haefner 2005, The vulvodynia guideline
Results of surgery

Published studies
- Retrospective (8)
- Prospective (6)
- Randomized (2)

Criticism of reported results
- Only 2 randomized studies, no control group
- Few participants
- Participants with various previous treatments
- Various surgical techniques
- Different outcome measures
- Varied length follow-ups
Result of surgery – randomized trial

• Bergeron et al 2001
  1. Surgery
  2. EMG-biofeedback 12 weeks
  3. CBT 12 weeks

• Outcome measures 6 months follow-up
  - Pain - cotton swab test, self reported dyspareunia, McGill Pain Questionnaire
  - Sexual function
  - Psychological adjustment

• Result
  1. Surgery – 15/22 complete relief or great improvement (68%)
  2. EMG-biofeedback – 10/28 complete relief or great improvement (36%)
  3. CBT – 11/28 complete relief or great improvement (39%)

• In an additional follow up study of the patients 2,5 years later the result was the same.
Results of surgery

- Significant pain reduction (VAS) in several studies
- Negative predictors - primary vestibulodynia and unprovoked pain
- Positive predictor – short term success = long term success

Side-effects from surgery

Serious side-effects are rare!

• Bleeding
• Haematoma
• Infection
• Insufficient healing – additional minor surgery
• Occlusion of the Bartholin’s duct in 9%

Haefner 2000, Goetsch 2009
Conclusion re surgery

• On the basis of the results of prospective and randomized trials, surgery is a successful treatment outcome for localised provoked vulvodynia.

• It is safe with few side-effects.

• However, there is a general agreement that surgery should not be a first line treatment and should only be performed when other treatments have failed.

Comments

• Patient selection is very important i.e. no concurrent skin disease

• Patients with primary provoked pain will less likely benefit from surgery.

• Treat vaginismus before surgery and after

• Inform the patient that it will take time to recover from surgery

• Postoperative psychological support
Characteristics of unprovoked vulvodynia

- Older patients, often post menopausal, but significant minority younger
- Unremitting burning/tingling
- No exacerbation with sexual intercourse
- Equated to trigeminal neuralgia and other pain syndromes
- Treated with Amitriptyline, Gabapentin, Pregabalin
- Physical therapies less successful usually
- CBT and other psychological approaches available
Physical therapies for vulval pain

• Biofeedback – Howard Glazer, difficult for many women, may increase pain for some, loss of confidence

• Physiotherapy – skilled professional, understands pelvic floor, will recognise pudendal neuropathy, will recognise sacro-iliac joint dysfunction, will recognise lower back problems

• Data supports role of physiotherapy in Vestibulodynia both as first line and support treatment – *emerging work suggests possibly > success than any other including surgery*
Treatment of all vulval pain

• May need combination depending on causation: local creams and systemic nerve-modifying agents
• Consider physical therapies e.g., physiotherapy, biofeedback
• Consider surgery in carefully selected cases
• Offer psychological support, psychosexual counselling, cognitive behavioural therapy, auto-hypnosis
• Holistic approach
• Remember at least 65% return to full sexual function
What can women do?

• Don’t use irritants – soap, salt, perfumes
• Use emollients
• Look at appearance
• Get advice – internet, support groups, doctors
• Keep complaining!
How are doctors training?

- GPs – majority so some gynaecology but limited learning about sexual function, vulval disease
- Dermatologists – lots of knowledge but may not have any specific experience of vulval skin disease
- Gynaecologists - all have some basic knowledge, advanced training available for some (enables then to run a vulval clinic level 2)
- Women need to have a voice with commissioners to insist on service development!
Summary

• Vulval disease including pain is manageable
• It is under diagnosed and poorly resourced
• Multidisciplinary approach: work with dermatologist, GUM physicians, plastic surgeons, physiotherapists, psychosexual counsellor
• Women need to know their bodies
• Help is available (Vulval Pain Association)
• Learn to look!