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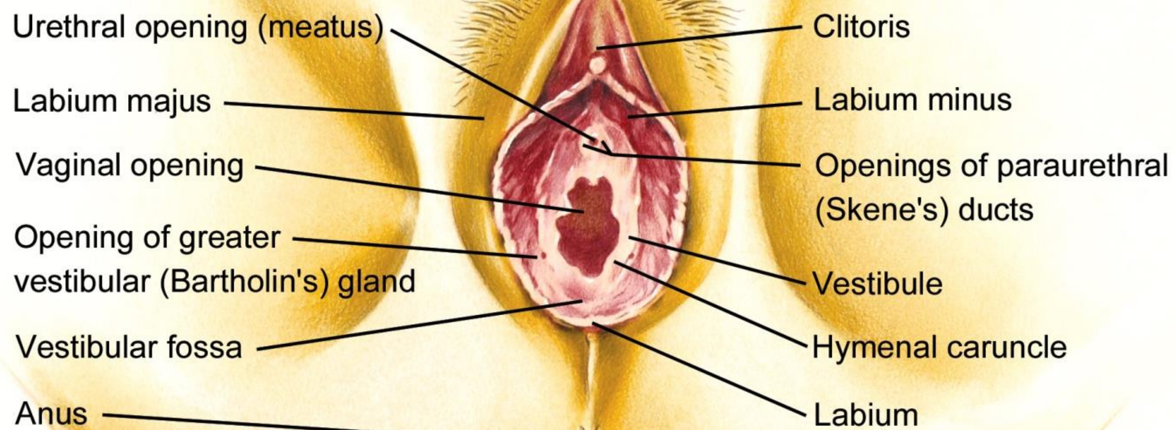
Vulval Pain – present knowledge May 2013

Wendy Reid

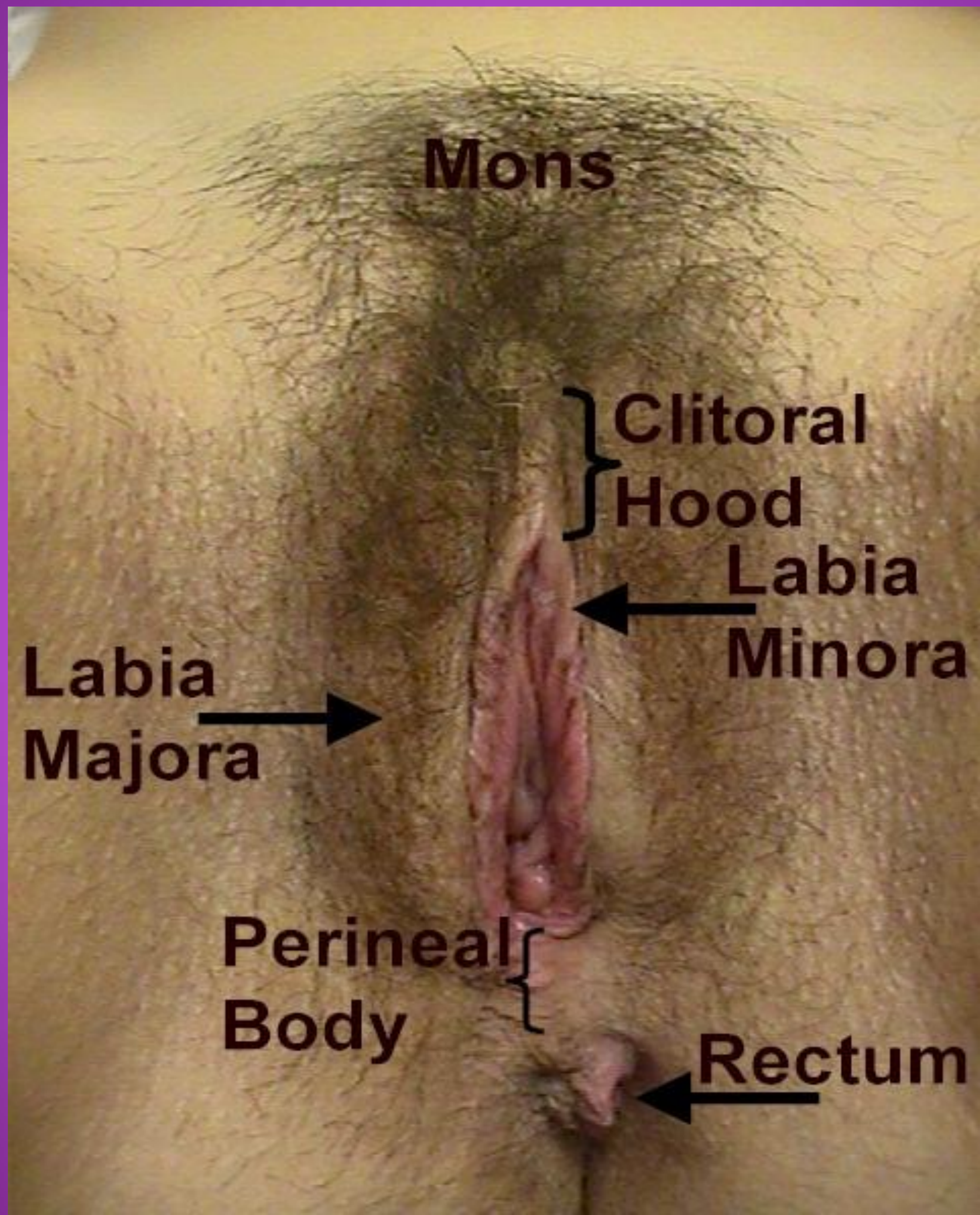
Vulval symptoms

- Itch (Pruritus)
- **Pain**
- Lump/lesion

'Not all itching is due to is thrush, not all pain is psychosomatic'



Urethral opening (meatus)
Labium majus
Vaginal opening
Opening of greater vestibular (Bartholin's) gland
Vestibular fossa
Anus
Clitoris
Labium minus
Openings of paraurethral (Skene's) ducts
Vestibule
Hymenal caruncle
Labium


Mons
Clitoral
Hood
Labia
Minora
Labia
Majora
Perineal
Body
Rectum

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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

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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**

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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**

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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

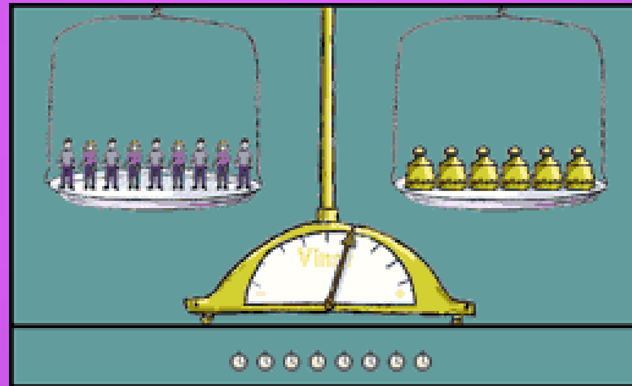
- Burning, rawness, splitting, at introitus
- Young women, usually premenopausal
- Entry dyspareunia
- Burning sensation lasts after intercourse
- Vestibular erythema – redness in circumference of entrance
- Q-tip tenderness over vestibular glands, just outside hymen
- Secondary > primary
- Primary more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

What is the etiology?

Psychosexual "triggers"

- sexual impairment
- anxiety
- depression
- previous trauma
- genetic factors
- others

Pain amplification



Multi-factorial

Physiological "triggers"

- infections
- treatments
- hormonal status
- immunological factors
- allergies
- genetic factors
- others

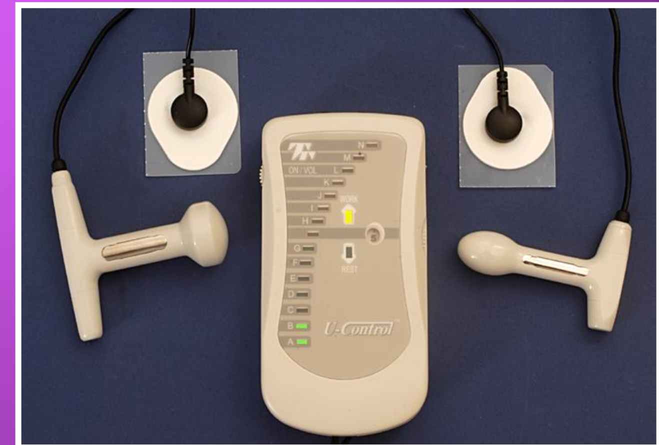
Nina Bohm-Starke, FIGO 2009

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, hynotherapy
- 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.

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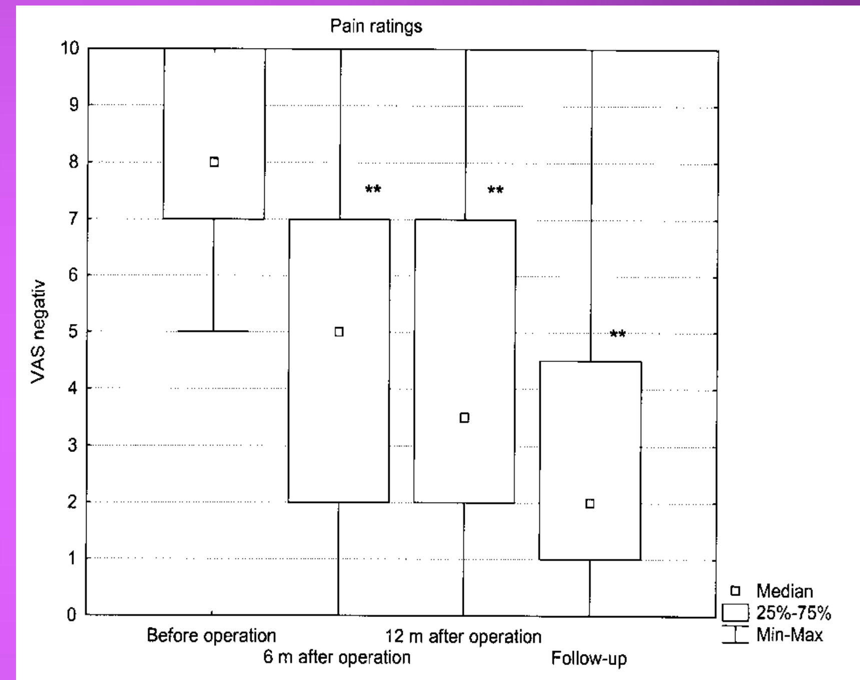
Results of surgery

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



Bornstein and Abramovici 1997, Bergeron et al 2001, Bohm-Starke and Rylander 2008, Eva 2007

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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

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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*

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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

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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!

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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!