Vulvodynia - Vulval Pain

BACKGROUND

Vulval pain **'Vulvodynia'** is defined by the presence of vulval discomfort, often burning in nature, in the absence of relevant clinical findings or a specific identifiable neurologic disorder(1). Vulvodynia is a clinical diagnosis. Vulvodynia can be further classified by location (generalised, or clitorodynia, vestibulodynia) and if it is unprovoked or provoked.

A thorough assessment of vulval pain should aim to investigate and treat or rule out medical causes for vulval pain.

Differential diagnoses of causes of Vulval Pain

Skin infections – for example *Herpes Simplex Virus 1 or 2* can cause prodromal or postherpetic neuralgia. *Vulvulovaginal Candida* can cause vulval itch associated with burning pain and often an altered vaginal discharge.

Inflammatory skin conditions such as *sebohorreic eczema, lichen sclerosus* or *planus* can cause pain and pruritis of the vulval skin and need to be ruled out as differentiatial diagnoses. *Vulval dermatitis* is a significant cause of vulval discomfort and may be due to exposure to soaps, panty liners, feminine hygiene products, hair removal products.

Consider **neoplastic skin conditions** (eg Paget's disease, squamous cell carcinoma, VIN) in anyone with atypical skin changes and localised discomfort.

Pudendal Neuralgia is an entrapment nerve syndrome and can present with pain in sitting, relieved by standing or lying.

Trauma including Female Genital Mutilation should be considered and covered in the history.

Hormonal changes – oestrogen deficiency (peri- or post-menopause, breastfeeding)

HISTORY

What should be covered: characteristics of vulval pain, exacerbating and relieving factors, time frame. Establish if vulval pain is provoked or unprovoked. Pain scales and diaries may be of use in longer term management.

Associated symptoms: itch, dyspareunia, abnormal vaginal bleeding, skin changes, vaginal discharge. Ask specifically about difficulties with sex (as these may not be volunteered and the impact of vulvodynia on sexual function is important), and difficulties with penetration to establish if there is co-existing element of vaginismus.

Sexual history – including if at increased risk of STI (age <25, new partner or more than one partner in past year, previous STI).

Pregnancy, risk of pregnancy, contraception use. Patient feelings and beliefs around pregnancy and infection may be of relevance.

Concurrent and recent medication: antibiotics, steroids, any home treatment.

Vulval skin care – patients should be encouraged to wash with soap only (or an emollient as soap substitute), use of any feminine hygiene products, hair removal, or panty liners can all irritate. Cotton only underwear should eb recommended.

Medical conditions – eg skin conditions as eczema or psoriasis. Diabetes (candidiasis).

Mental health history, including any present features of anxiety or depression; these conditions are significantly higher in women presenting with vulvodynia

Previous gynaecological procedures, previous infections (for example vulvovaginal candidiasis)

Always offer examination.

Always consider pregnancy in a patient who is sexually active prior to any treatment.

Abdominal and PV examination: abdominal palpation for tenderness or mass. Inspect vulva for discharge, erythema, ulceration, skin lesions or changes.
If acceptable to patient, gentle palpation around vulva and at introitus to establish if discomfort is elicited.
Bimanual exam, if acceptable to patient, to assess if there is any degree of hypertonicity of pelvic floor which may suggest vaginismus (NOTE that vaginismus can often be situational, so examination can be normal, but a clear history of vaginismus during for example penetrative sex may be present in the absence of hypertonicity on examination).

Investigations:

1. Should be tailored to findings on history and examination. These may include candida swab, swab for STIs CT/GC (in addition consider PCR for trichomonas vaginalis can cause vulval irritation and sometimes an offensive smelling discharge).
2. For any atypical skin lesions suspicious of malignancy, 2WW referral.

TREATMENT

General advice should be given to all patients regarding **vulval care**. Advise to not douche, wash only with water, moisturise with emollient, avoid tight synthetic clothing.
Treatment of Vulvodynia – vulval pain without a medically identified cause –should be tailored to the individual, combining treatments is recommended (1,2), and a symptom diary may help monitor response.
Reassurance (that the condition is not infectious or related to cancer) may be an important aspect of management. The patient information leaflet here: https://www.bad.org.uk/shared/get-file.ashx?id=186&itemtype=document

Medical treatments

A **topical local anaesthetic agent** (eg Lidocaine 5% ointment, which can be applied topically for 4-6 weeks) can be trialled with all patients with Vulvodynia.

Tricyclic Antidepressants (TCAs) eg Amitryptiline or Nortriptyline are an appropriate initial treatment in unprovoked vulvodynia, and can be titrated up from 10mg in increments of 5-10mg fortnightly to a maximum of 100mg.The average dose is 60mg. Side effects should be discussed and monitored. Some patients may find that side effects outweigh benefits.

Gabapentin and Pregabalin may be considered, this would usually be with the involvement of specialist pain services.

Consider **oestrogen creams** if there is an element of oestrogen insufficiency (peri or post-menopause, breastfeeding). (Eg Estriol 0.01% cream nightly for 2-4 weeks then twice weekly) or Estradiol 10 micrograms daily for 2 weeks, then reduced to 10 micrograms twice weekly.

Multidisciplinary team input

Pelvic floor muscle dysfunction or hypertonicity should be addressed in patients with evidence from history or examination of vaginismus. Women's Health or **Pelvic Floor Physiotherapy** referral should be considered.

Pain management team referral considered for all patients with severe pain or no improvement from initial management.

Consideration of referral to **a specialist psychosexual medicine clinic**, or for psychosexual counselling, if sexual dysfunction is an element of the presenting problem. All East accepts referrals for psychosexual assessment.

REFERENCES

1 Mandal D, Nunns D, Byrne M, McLelland J, Rani R, Cullimore J, Bansal D, Brackenbury F, Kirtschigg G, Wier M. Guidelines for the management of vulvodynia. British Society for the Study of Vulval Disease Guideline Group. British Journal of Dermatology. 2010. 162, pp1180-1185

2 Committee on Gynecologic Practice. Persistent Vulvar Pain, The American College of Obstetricians and Gynaecologists. 2016. N 673 https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2016/09/persistent-vulvar-pain.pdf

Patient information resources:

https://www.bad.org.uk/shared/get-file.ashx?id=186&itemtype=document

Vulval pain society:

https://vulvalpainsociety.org/

National Vulvodynia Association self-help guide:

https://www.isswsh.org/images/PDF/NVA.Self-help.guide.pdf