New ISSVD Nomenclature of Vulvar pain: implication on patient assessment

**Vulvodynia**

**Definition**
Chronic vulvar pain or discomfort for which no obvious etiology can be found

Years of pain prior to diagnosis!

Represents a significant burden for...women...

and for health care providers!!

**What can I do?**

Years of pain prior to diagnosis!

**Number of physicians consulted**

Commonly misdiagnosed

Real challenge

**Vulvodynia**

**Prevalence**

She remembers her vulva all day long!!

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Prevalence throughout life is 4 to 16% and remains constant across all decades

Affects women of all ages and ethnicities

1 - Sadowni L. «Etiology, diagnosis and clinical management of vulvodynia».
Int J Women’s Health 2014;6:437–449


Various terms used for Vulvar Pain prior to 2003

- Essential Vulvodynia
- Dysesthetic Vulvodynia
- Vulvar Vestibulitis Syndrome
- Vulvar Dysesthesia (Generalized or Local)
- Provoked Vulvar Dysesthesia
- Spontaneous Vulvar Dysesthesia

Vulvar Pain 2003 ISSVD Terminology and Classification

- Vulvar pain related to a specific disorder
  1. Infectious (candidiasis, herpes, etc)
  2. Inflammatory (LP, immunobullous disorders)
  3. Neoplastic (Paget’s disease, carcinoma)
  4. Neurogenic (herpetic neuralgia, spinal nerve compression)

- Vulvodynia
  - Generalized
    - Provoked*
    - Unprovoked
    - Mixed
  - Localized
    - Provoked*
    - Unprovoked
    - Mixed
  *Provoked: sexual, non-sexual or both
Localized Vulvodynia

Generalized Vulvodynia

VULVODYNIA
Vulvar pain WITHOUT apparent cause, after having ruled out all specific disorders.

A. Vulvar pain caused by a specific disorder

- Infectious (e.g. recurrent candidiasis, herpes)
- Inflammatory (e.g. lichen sclerosus, lichen planus, immunobullous disorders)
- Neoplastic (e.g. Paget disease, squamous cell carcinoma)
- Neurological (e.g. herpetic neuralgia, nerve compression or injury, neoma)
- Trauma (e.g. female genital cutting, obstetrical)
- Iatrogenic (e.g. post-operative, chemotherapy, radiation)
- Hormonal deficiencies (e.g. Genito-urinary Syndrome of Menopause [Vulvo-vaginal atrophy], lactational amenorrhea)

B. Vulvodynia – (Vulvar pain of at least 3 months, without clear identifiable cause, which may have potential associated factors)

- Descriptors:
  - Localized (vestibulodynia, clitorodynia, or other localized areas) or Generalized or mixed (localized and Generalized)
  - Provoked (e.g. insertion, contact) or spontaneous or mixed
  - Onset (primary or secondary)
  - Temporal pattern (intermittent, persistent, constant, immediate, delayed)

*Women may have both a specific disorder (e.g. Lichen Sclerosus) and Vulvodynia

2015 Consensus terminology and classification of persistent vulvar pain

Jacob Bornstein MD, Andrew Goldstein MD and Deborah Coady MD

From the ISSVD, ISS WSH, IPPS

Appendix: Potential factors associated with Vulvodynia

- Neuroproliferation [Level of evidence 2b, Grade B]
- Musculoskeletal (e.g. pelvic muscle overactivity, myofascial, biomechanical) [Level of evidence 1b, Grade A]
- Inflammation [Level of evidence 2b, Grade B]
- Psychosocial factors (e.g. mood, interpersonal, coping, role, sexual function) [Level of evidence 2b, Grade B]
- Genetics [Level of evidence 2b, Grade B]
- Hormonal deficiencies (e.g. pharmacologically induced) [Level of evidence 2b, Grade B]
- Neurological mechanisms: Central (spine, brain) [Level of evidence 2b, Grade A]
  - Peripheral [Level of evidence 2b, Grade B]
- Structural defects (e.g. perineal descent) [Level of evidence 2b, Grade B]
- Co-morbidities and other pain syndromes (e.g. painful bladder, fibromyalgia, IBS, TMD) [Level of evidence 2b, Grade A]
Vulvodynia

Diagnosis

Von Frey filaments?

Cotton swab test

Vulvoscopy?

Von Frey filaments are less suitable devices than cotton swabs for the assessment of disease severity and response to treatment.

Donders GG. J Reprod Med 2014;59:134-8

Not tender; no area of vulva touched described as area of burning or pain.

Alternative Diagnosis

Localized Vulvodynia

Generalized Vulvodynia

Etiology

Multifactorial

Multifactorial

Etiologic Theories

Embryologic development

Urogenital sinus and LGT have a common embryologic origin.

Irritable bowel syndrome/interstitial cystitis/fibromyalgia

Embryologic development

Irritable bowel syndrome

Interstitial cystitis

Fibromyalgia

Orofacial pain

Predispose to similar pathological responses
2015 ISSVD Classification of Persistent Vulvar Pain

Appendix: Potential factors associated with Vulvodynia

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Vulvodynia

Homonal deficiencies

Oral contraceptive pills use and Vulvodynia

For women under 50, OC use did not increase the risk of subsequent vulvodynia

Champaneira et al. 2016

OC may have an effect on pelvic floor function
Could increase the risk of painful bladder and VD

Vulvodynia

Homonal deficiencies

Variation in pain pre and postmenopause

71% of postmenopausal women reported vestibular dyspareunia related to a descent in estrogen either with menopause or previously.
86% of postmenopausal women were using E but referred persisting pain.

Lelnaire, 2013

2015 ISSVD Classification of Persistent Vulvar Pain
(Accepted: July 28, 2015)

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Psychosexual problems

MULTIFACTORIAL

Frequent 40-55% sexually active people

Causes

Demographic factors
- Lack of information regarding women’s sexuality
- Stress, work and economic problems
- Relationship dysfunction
- Menopause, body image changes
- Partner’s sexual dysfunction

Lack of information regarding women’s sexuality

How men and women are turned on...

Stress, work and financial problems

We are too stress, very busy and exhausted to have sex
Stress, work and financial problems

NOT TODAY

Relationship problems

Menopause

Sexual capacity does not disappear with age
It only decreases in intensity
Hormone deficiencies do exist and can be solved
The problem lies among those women who have NEVER enjoyed good and healthy sexuality

Menopause, changes in body image.

All of these issues lead to not having sexual desire and vulvodynia turns out to be the perfect excuse.
**Vulvodynia**

The following are critical therapeutic elements:

- Complete interview
- Evaluate psychological factors
- Knowledge of vulvar diseases and female sexuality. The focus of treatment should be on the woman in pain, and not the pain in isolation
- Psychological and/or sexual counseling

**Research regarding the medical treatment of VD has failed to identify a convincing therapeutic intervention**

**TREATMENT**

Interdisciplinary

- Explain the patient that her symptoms are REAL
- Pain will not last for ever (41% Spontaneous resolution in 2 years)
- Needs time, communication and patience!!!
- INDIVIDUALIZED


- Educate patients
- Eliminate irritants
- Topical treatments
- Topical injections
- Oral treatments
- Physical therapy
- Counselling/ cognitive behavioral therapy
- Surgery
Hygiene

- Vaginal douching should be avoided
- Avoid use of pantyliners
- Avoid scented soaps
- Avoid hair removal

Vulvodynia

TREATMENT

Eliminate irritants

- Local estrogens
  - Possibly decreased E receptors
- Topical anesthetics: Lidocaine jelly 2% or 5% during night for 8 weeks
  - 76% were able to have intercourse compared with 36% prior to treatment. Zolloun et al.
- Topical antipruritics: 56% of patients responded to treatment
  - Triamcinolone 0.5 cc, If beneficial, may repeat 6 weeks
  - No difference in visual analog scale
  - Nerve blocks
    - Botulinum toxin: Minimize vaginismus, relax
      - Direct pain effect?

Topical injections

- Corticosteroids
  - Into trigger points if present
- Nerve blocks
- Botulinum toxin

Vulvodynia

Oral treatments

- Venlafaxine: 37.5 mg, increase weekly to 150 mg
  - No published data on VD
  - Nausea, Drowsiness, Insomnia
  - Dizziness, Dry mouth, Sexual side effects
- Tricyclic medication: Amitriptyline vs placebo
  - No difference in these groups
  - Amitriptyline: Starting with 10 mg/day, increase weekly up to 150 mg
    - Drowsiness, tachycardia, dry mouth, increased appetite, constipation
  - Tricyclic medication: Amitriptyline

Antidepressants

- Venlafaxine
- Tricyclic medication

- Help with associated anxiety and depression
- Do not refer to them as antidepressants but as medication for neuropathy pain

Anticonvulsants

- Pregabalin

- Start 25 mg increase up to 300 mg
  - May be faster in onset, expensive
- Retrospective of 28 women
  - 12 improvement (62%)
  - 10 discontinued due to Aes
  - 4 no improvement and 2 not tested pain
- Dizziness, peripheral edema, weight gain, somnolence
- Less well tolerated than Gabapentin
Vulvodynia

Oral treatments

- Start at 300 mg up to 3600 mg
- May be faster in onset, expensive

Methodologic weaknesses

Dizziness, peripheral edema, somnolence, fuzziness

Gabapentin

Spoelstra SK. J. Psychosom Obstet Gynecol 2013;34:133-8

Vulvodynia

Pelvic floor therapy

Before & After

Associated with pelvic floor muscle dysfunction

Vulvodynia

Psychosocial therapies

Couple’s counseling

Cognitive behavioral therapy

Psychotherapy

Vulvodynia

NEW: Anecdotal medications

- Topiramate
  - Used for migraines
  - No data for VD
  - Both can interfere with hormonal contraception

- Lamotrigine
  - Open-label pilot trial study
  - Success: (50-82%)

Vulvodynia

Associated with pelvic floor muscle dysfunction

a) High resting tension
b) Irritability and tenderness of muscles
  - My favorite single therapy with counseling and sex therapy
Jen Langford

Vulvodynia: a) High resting tension
  b) Irritability and tenderness of muscles
  c) Poor strength
  d) Coexisting
    - Irritable bowel syndrome
    - Urinary tract symptoms

Cognitive behavioral therapy

Improve well-being

- Education about normal anatomy and female sexuality. BREAK THE ROUTINE!
- Discussion of sexual stimuli and sexual activities other than intercourse

Basic sex counselling

Psychological treatment

- Continues to be the mainstay in management of VD
  Cognitive behavioral therapies
Cognitive behavioral therapies

- Techniques which consist of exchanging physical contact, moving from nonsexual to sexual touching
- Encourage the couple to guide each other regarding their required or preferred sexual stimulation

Vulvodynia

Surgery

- Areas of pain mapped by Q-tip test
- Excision removes the painful area of vestibule (including the hymenal ring)
- Vaginal skin is externalized to cover the resulting defect

Vulvodynia

Surgery

- Early success: about 60%
- Recent reports: 85%
- Better outcomes in combination with pelvic floor rehabilitation
- Retrospective study of 67 women
- Complete or major improvement was reported by 56% of women with secondary vestibulodynia and 17% with primary vestibulodynia

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PLACEBO

50% SUCCESS

WE NEED RCT vs PLACEBO

We must consider this effect when interpreting “success” rates of any given intervention
The optimal therapy for vulvar pain syndrome remains elusive, with low percentages of therapeutic success, using either local or systemic pharmacological approaches.

The best physician is the one who has earned the patient’s trust

Is not necessarily forever...

Future ...

Provide and discuss all therapeutic possibilities

Support them!

Thank you

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