Management of Vulvodynia:
VGH Multidisciplinary Vulvodynia Program

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Goal

- Share one approach to managing patients presenting with vestibulodynia with a focus on
  - patient education,
  - pain relief,
  - cognitive behavioural therapy,
  - physical therapy

Vulvodynia

- Chronic vulvar discomfort
- characterized by *burning, stinging, irritation or rawness* of the female genitalia with no obvious cause
- Generalized vs. localized
- Provoked vs. unprovoked

Vestibulodynia
Diagnostic criteria

Vestibulodynia

- severe pain during attempted vaginal entry
- tenderness to pressure localized in the vulvar vestibule
- redness of the vulvar vestibule

Patient report of pain alone is a reliable diagnostic indicator.
Although these criteria are useful, there is a spectrum of presentations.

Spectrum

- Daily vulvar sx
- bladder and bowel sx
- Cyclic "irritative" symptoms
- Pain with tampon insertion
- Pain with pelvic examination
- Pain with sexual intercourse

Assessment & Patient Education

MEDICAL
THERAPY

COGNITIVE
BEHAVIORAL
THERAPY

Assessment

- Interpret gram stains correctly
- If in doubt about yeast try a prophylactic 8 week course of antiyeast
- Follow-up with cultures & pain diary
- Biopsy = inflammation

Patient Education

Patient education alone is effective in
reducing pain and improving sexual function

- Handouts
- Useful books & journal articles
- Media articles (Globe & Mail, NY Times)
- Useful websites:
  - www.mvprogram.org
  - www.nva.org

Pain Relief

- Skin care
- General symptom management
- Topical lidocaine
- Injectable lidocaine with steroid
- Oral pain adjuvants
- Surgery

Skin Care & Vulvar Hygeine

Vulvar skin care

- Avoid chemicals and synthetic fibers
- moisturizer/emollient
- Penaten barrier
- No panty liners

Symptomatic measures

- ice packs (≤10 mins at a time)
- Topical xylocaine
- Topical EMLA
- Lubricating agents (Astroglide, Replens, personal KY Jelly)

Pain Relief: Topical

- Estradiol 0.1% in glaxxo base apply BID for 6 weeks
- **2 – 5 % Lidocaine** gel/ointment apply nightly for 6 weeks

Pain Relief: Injectable

- Submucous infiltration of a solution of methyprednisolone (40mg) and lidocaine (10 mg in saline) into vestibule
  - 1 ml week 1
  - 0.5ml week 2
  - 0.3 ml week 3

+ Oral Medication

- Ketoconazole/fluconazole 150 mg weekly x 8
- Amitriptyline Start 25 mg increase 25mg per week to 150mg (nortriptyline better tolerated) x 3 months
- Gabapentin
  - Start 100 mg, increase by 100 mg q2 days up to 300 mg, then slowly increase to 300 mg TID (max dose 3600 mg daily) x 3 months

Pelvic Floor Problems

- ❑ Muscular instability at rest
- ❑ Poor muscle recovery
- ❑ Elevated resting baseline tension
- ❑ Reduced muscle activity
- ❑ Reduced contraction strength
- ❑ Vaginismus

Physical Therapy

- ✓ Superficial perineal massage
- ✓ Pelvic floor physiotherapy
- ✓ **Biofeedback**
- ✓ TENS
- ✓ accupuncture

✓ Vaginal inserts

Sexual Health

❑ Sex associated with pain
❑ Loss of sexual interest,
❑ Inhibited arousal and response,
❑ Low sexual self-esteem
❑ Diminished emotional, physical and sexual intimacy

Sexual Health

✓ Discuss a women's sexual response cycle and how it is interrupted by painful sexual experiences
✓ Stress importance of sexual context
✓ Non-penetrative sexual pleasuring
✓ Focus on receptive sexual drive

Cognitive Therapy

❑ Thoughts and feelings affect pain
❑ Patients prone to catastrophic thoughts
  ❑ "I will never have normal sex"
  ❑ "My partner will leave me"
  ❑ "There must be something really wrong with me"
❑ Chronic anxiety can lead to depression and decreased coping ability

Therapy

✓ Patients can learn ways to reduce anxious thoughts and tension
  ✓ mindfulness practice,
  ✓ progressive muscle relaxation,
  ✓ thought checking – reframing & positive affirmations "I am a sensual person" "The pain will go away if I …"

Assessment & Patient Education

MEDICAL
THERAPY

COGNITIVE
BEHAVIORAL
THERAPY

A RCT Bergeron et al
(Pain 2001;1:297-306)

Complete relief or great improvement of pain at

- Vestibulectomy 15/22
- GCBT x 12 wks 11/28
- Biofeedback x 12 wks 10/28
- Treatments gains maintained
- Participants continued to improve

Self report pain during intercourse Scale 1-10

Vestibulectomy

- excision of the posterior hymen and the painful mucosa of the anterior and or posterior vestibule to a depth of 2 – 5mm.
- If necessary the vaginal mucosa is mobilized and brought downward to cover the excised area.
- Success 43-100% (majority >66%)

Promising Treatments

- **Patient Education**
- **Group Cognitive Behavioural therapy**
- **Biofeedback**
- **Lidocaine 5% only nightly**
- **Surgery**

References

- Vulvar Vestibulitis Syndrome: A Critical Review (Bergeron et al. Clin J Pain Vol 13(1) 1997)
- The Treatment of Provoked Vestibulodynia. A Critical Review (Landry et al. Clin J Pain Vol 24(2) 2008)
- The Vulvodynia Guideline Journal of Lower Genital Tract Disease Vol 9, 1, 2005, 40-51
- UpToDate Guideline Vestibulodynia