Diagnosis and Management of Vulval Pain

Reference no.: UHDB/Gynae/07:23/V1

Contents

1. Introduction

Vulvodynia is a painful gynaecological disorder characterised by chronic vulval pain, physical disability, sexual dysfunction and affective distress. It is estimated that around 16% of women will suffer from vulval pain at any time in their life. The condition is observed in all decades of life until age 70. Despite the high prevalence, it is still an underestimated condition, as it can potentially be dismissed as a psychological condition.(1)

2. Purpose and Outcomes

The purpose of this guideline is to provide clear diagnostic criteria and algorithms for managements of vulval pain within UHDB.

3. Abbreviations

GVD - Generalised Vulvodynia
ISSVD - International Society for the Study of Vulvovaginal Diseas

4. Definitions and Classification

The 2003 ISSVD Terminology and Classification of Vulvodynia divided vulval pain into two major groups:

- Vulval pain related to a known disorder
- Vulval pain in the absence of relevant visible finding or clinically identifiable disease. This second group is termed vulvodynia.

The most recent terminology and classification of vulval pain is the 2015 Consensus terminology and classification of persistent vulval pain (2) which classified Persistent Vulval pain into:

A. Vulval pain caused by a specific disorder*

- Infectious (e.g. recurrent candidiasis, herpes)

- Inflammatory (e.g. lichen sclerosus, lichen planus)
- Neoplastic (e.g. Paget disease, squamous cell carcinoma)
- Neurologic (e.g. post-herpetic neuralgia, nerve compression or injury, neuroma)
- 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
Vulval pain of at least 3 months duration, without clear identifiable cause, which may have potential associated factors.

Descriptors:
- Localized (e.g. vestibulodynia, clitorodynia) or Generalized or Mixed (localized and generalized)
- Provoked (e.g. insertional, contact) or Spontaneous or Mixed (provoked and spontaneous)
- Onset (primary or secondary)
- Temporal pattern (intermittent, persistent, constant, immediate, delayed)

5. Clinical Manifestations and Diagnosis

Common presentations include:(3)
- Discomfort with separation of the labia minora.
- Dyspareunia from pain on penetration through the vestibule
- Point tenderness localized to area surrounding the Skene gland orifices or the Bartholin gland openings within the vulval vestibule.

Initial assesment by a detailed history and examination aims to exclude specific condition that can cause vulval pain. These Include:

5.1 History
Directed history to exclude potential factors associated with Vulvodynia:
- Co-morbidities and other pain syndromes (e.g. Painful bladder syndrome, fibromyalgia, irritable bowel syndrome, temporomandibular disorder)
- Neurologic conditions: Post-herpetic neuralgia, nerve compression or injury, neuromas.
- Musculoskeletal (e.g. Pelvic muscle over-activity, myofascial, biomechanical)
- Iatrogenic: post-operative, chemotherapy, radiation.

5.2 Examination
General Examination
- Skin, mouth & nails
  Look for signs of extra genital lichen planus, psoriasis, Paget's disease or eczema.
- Pelvic Floor:
  It is important to examine for tenderness and muscle tone, although if the patient is apprehensive, a detailed examination would be better performed by a physiotherapist experienced in this field.
- Examination of the vulva: To rule out
  Infections: Microbiologial swabs for Candidasis. Herpes etc.
- Inflammatory conditions: Lichen sclerosis, Lichen planus,etc by visual inspection with or without biopsy of any suspicious lesions.
- Neoplastic conditions: squamous cell carcinoma, Paget's disease, etc by visual inspection with or without biopsy of any suspicious lesions.
- Traumatic causes: female genital cutting, obstetrical trauma.
- Hormonal deficiencies : Atrophic changes of menopause , lactational amenorrhea.

Once a specific cause is excluded, a diagnosis of **Vulvodynia i**s made. The diagnosis of localised vulval pain is one of exclusion, made primarily on the history and examination.

5.3 Vuvodynia Clinical Workup

- **Visual inspection:**
  Vulval erythema on visual inspection at the vestibule may be a significant finding in localised vulvodynia but can be nonspecific as it can be observed in normal women. The vulva on examination in generalised vulvodynia (GVD) is usually normal.
- **Pain mapping with 'Q-tip' test to identify:**
  - Distribution : generalized or localized.
  - Assess if pain is unprovoked or provoked: Provoked pain is illustrated as tenderness to pressure and touch (Q-tip test) in a focal area (often the vestibule) without identification of any known cause.
- **The bulbocavernous reflex** (elicited by gently stroking the labia majora) and the anal wink tests are done to rule out peripheral neuropathy

5.4 Generalized Vulvodynia

- Generalized vulvodynia refers to burning, stinging, soreness, pain, irritation, or rawness anywhere on the vulva, perineum, or peri-rectal area.
- Usually sudden in onset, and can occur at any age.
- This could be :
  - Provoked (brought on by touch, movement, sexual activity) or
  - Unprovoked (spontaneous, without any obvious trigger), or a
  - Combined (mixed).
- The pain may be constant or sporadic, present for hours, days, weeks, then regressing.
- It may be diffuse without clear borders, or focal, or may alternate in location.

5.5 Localized Vulvodynia

- Previously referred to as vulval vestibulitis, clitorodynia, hemivulvodynia, etc.)
- Usually suggestion of localized provoked pain which often starts out as being provoked, but persists as spontaneous or both provoked and spontaneous pain.

Refer to algorithm on Appendix A

6. <u>Treatment Options</u>

6.1 General Principles

The approach to women with vulval pain or vulvodynia should include assessment of the degree of the symptoms and the impact on their daily activities including their sexual function.
Treatment must be individualized and a multidisciplinary team approach is needed to address the different components of each case.
A lead clinician should triage patients and consider referral to other health professionals who have a role in vulvodynia management, e.g. psychosexual medicine, physiotherapy, clinical psychology, and pain management teams.(4) Patients not responding to standard treatment or with complex vulval dermatological co-morbidities should be referred to specialist vulval service.

6.2 Vulval Care Measures

- Identify and eliminate any possible pain triggers.
- Vulval irritants and douching should be avoided.
- General vulval skin and hygiene care advice should be given. Cotton underwear is recommended.
- The patient should use mild soaps for bathing and not apply soaps to the vulva.
- If menstrual pads are irritating, 100% cotton pads may be helpful (consider prior application

of a barrier emollient).
- Adequate lubrication for intercourse is recommended.
- Provide patient with written information. (5) See appendix 2 for relevant resources for patients.

6.3 Educate about Vulval Pain

Use handouts (to patient handouts), website referrals,. Emphasize that pain may need to be managed, not cured. Offer counseling for support, anxiety, depression, or relationship problems. Relevant Patient Information leaflets

6.4 Topical Medications

- Topical anesthetic ointments: **Lidocaine 5% ointment**
  - For local application or for deep perineal massage for desensitization on the areas of tenderness have had some benefit in reducing the allodynia response on the vulva
  - For topical application in women with provoked vestibulodynia making penetrative sex possible- generally advised to apply 15–20 min prior to sex, avoiding clitoral area. Warn patients about irritancy, potential effects to the partner such as penile numbness (male partners may want to wear condoms or wipe away any excess prior to penetration), and to avoid oral contact.
  - Women with generalized vulvodynia or vulval pain from a known cause often benefit from lidocaine during pain or itching flares.
- **Vaginal Estrogen** if any evidence of vaginal atrophy, especially in peri-menopausal or post-menopausal women
- **Lubricants** for sexual intercourse.

6.5 Tricyclic Antidepressants (TCA)

Tricyclic antidepressants (amitriptyline, nortryptiline,) are considered effective compounds in the treatment of neuropathic pain and are a common treatment for vulvodynia. Emphasize to patients that tricyclics are being used for pain, not depression, although the anti-depressant effects may be useful. Nortriptyline is less sedating than amitriptyline and has fewer anticholinergic side effects (dry mouth, constipation, sweating, palpitations).
Amitriptyline:10mg daily increasing every week until the pain is controlled has been suggested). The average dosage is 60mg daily (although up to 100mg daily can be used)

6.6 Neuromodulators: Pregablin and Gabapentin

If there is no response or intolerant to TCA, consider referral to the **Pain Team** for further assessment. Increasing dosage of Pregabalin or Gabapentin might be required for optimal management .
Pregabalin 50 mg po od - Can gradually increase up to 100 mg BD. Maximum dose 300 mg BD
Gabapentin : start at 300mg orally and increase by 300mg every 3 days to a maximum dosage of 1800 mg daily

6.7 Physiotherapy for Pelvic Floor Muscle Dysfunction

Pelvic floor dysfunction should be addressed in patients with vulvodynia who have sex-related pain. Techniques to desensitize the pelvic floor muscles are likely to be beneficial. Patients can be taught a variety of self-help techniques including pelvic floor exercises, external and internal soft tissue self-massage, trigger point pressure, biofeedback and use of vaginal trainers. Consider referral to the Continence Team pelvic floor physiotherapy.

6.8 Surgery (Limited evidence only as last resort in selected cases)

Vestibulectomy : Surgical excision of the vestibule may be considered in patients with local provoked vulvodynia (vestibulodynia) after other measures have been tried. Only a minority of patients may be suitable for surgery. If surgery is offered, adequate counseling and support should be given to the patient both pre- and postoperatively.(6)

6.9 Alternative and Supportive Approaches

- Intralesional and trigger point injections in cases of provoked vulvodynia: Consider referral to the Pain team if suggestion of an obvious neurological cause, like Pudendal neuralgia.
  - Subcutaneous injection of steroids and local anesthetics (40 mg methylprednisolone acetate and lidocaine in 10 mL of normal saline into the vestibule)
  - Botox injections to treat allodynia (limited success and likely need for repeated injections)
- Acupuncture can be considered in cases of unprovoked vulvodynia. (7)
- Hypnotherapy,Mindfulness,Cognitive behavioural therapy might be useful in selected cases

7. Monitoring Compliance and Effectiveness

As per agreed business unit audit forward programme

8. References

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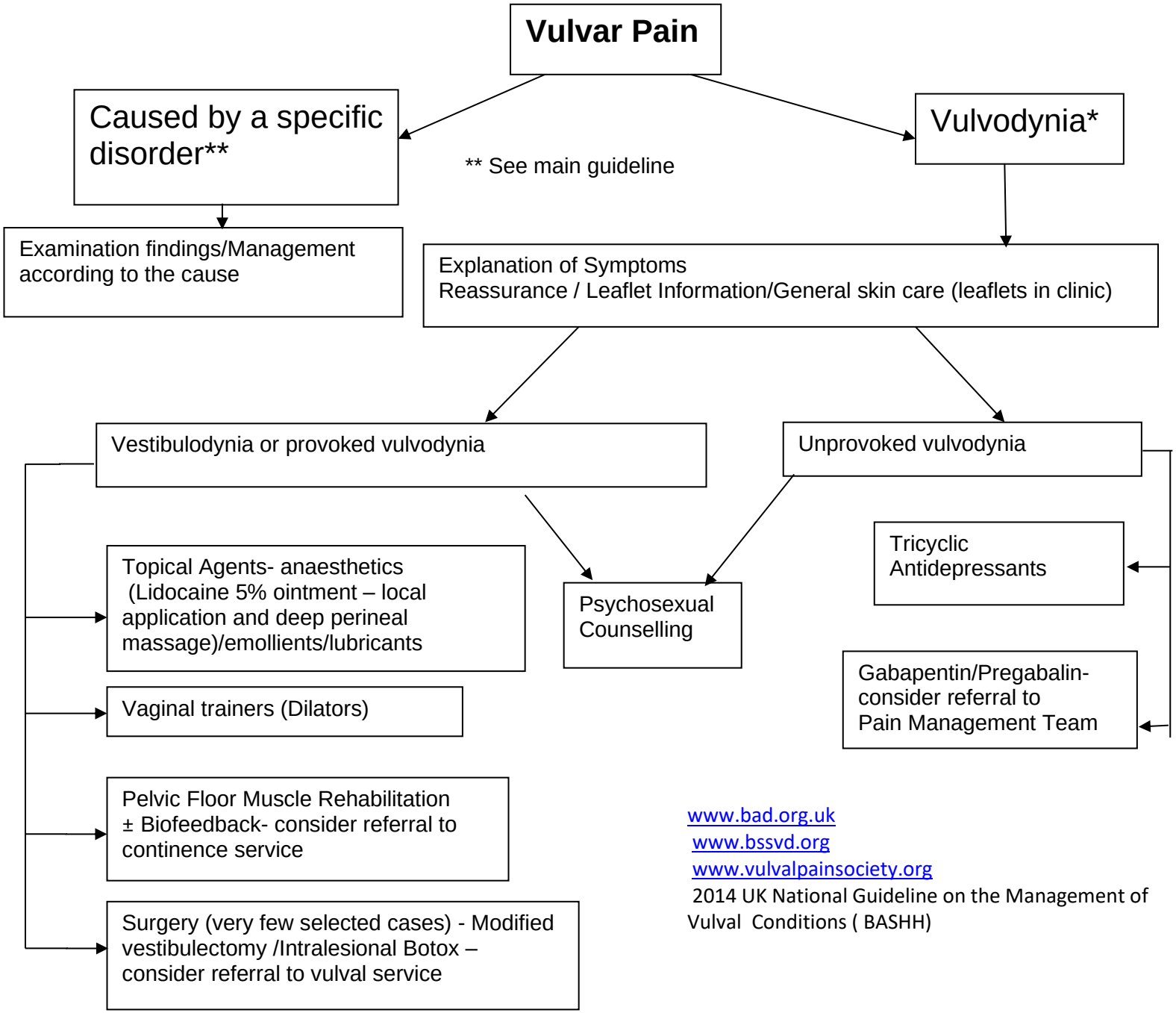
ALGORITHM FOR VULVODYNIA

Appendix A



*Generalised OR Localised (vestibulodynia, clitorodynia etc)

- Provoked (sexual, nonsexual or both)
- Unprovoked
- Mixed (provoked and unprovoked)

Source: ISSVD 2005

www.bad.org.uk
www.bssvd.org
www.vulvalpainsociety.org
2014 UK National Guideline on the Management of Vulval Conditions (BASHH)

Appendix B

RESOURCES FOR PATIENTS

1. Genital care for women : ISSVD Leaflet: https://3b64we1rtwev2ibv6q12s4dd-wpengine.netdna-ssl.com/wp-content/uploads/2016/04/GenitalCare-2013-final.pdf(8)

2. General Vulval Care: Vulval pain Society: http://www.vulvalpainsociety.org/vps/index.php/advice-and-self-help/general-advice(9)

3. Skin Conditions of the vulva .RCOG Patient information leaflet on: https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/gynaecology/skin-conditions-of-the-vulva.pdf (10)

4. Vulvodynia: a Self-Help Guide.National Vulvodynia association: https://www.nva.org/getfile/self-help-guide-pdf-pdf(11)

5. Generalized unprovoked vulvodynia . ISSVD Guidance for patients: https://3b64we1rtwev2ibv6q12s4dd-wpengine.netdna-ssl.com/wp-content/uploads/2016/04/Vulvodynia-2013-final.pdf(12)

6. Vuldodynia .Vulval pain society patient Guidance on:http://www.vulvalpainsociety.org/vps/index.php/vulval-conditions/vulvodynia (13)

Q TIP TEST

A moistened cotton swab test is applied with gentle pressure to the inner thigh, labia majora, interlabial sulcus, clitoris, and perineum and at 2, 4, 6, 8 and 10 o'clock positions along the vestibule. This pressure elicits discomfort in women with vulvodynia especially at the posterior introitus and hymenal remnants. The presence of allodynia and hyperaesthesia throughout the vestibule suggest intrinsic pathology due to neuronal proliferation in the vestibule and if perceived in the posterior vestibule is suggestive of hypertonicity of levator ani muscles.

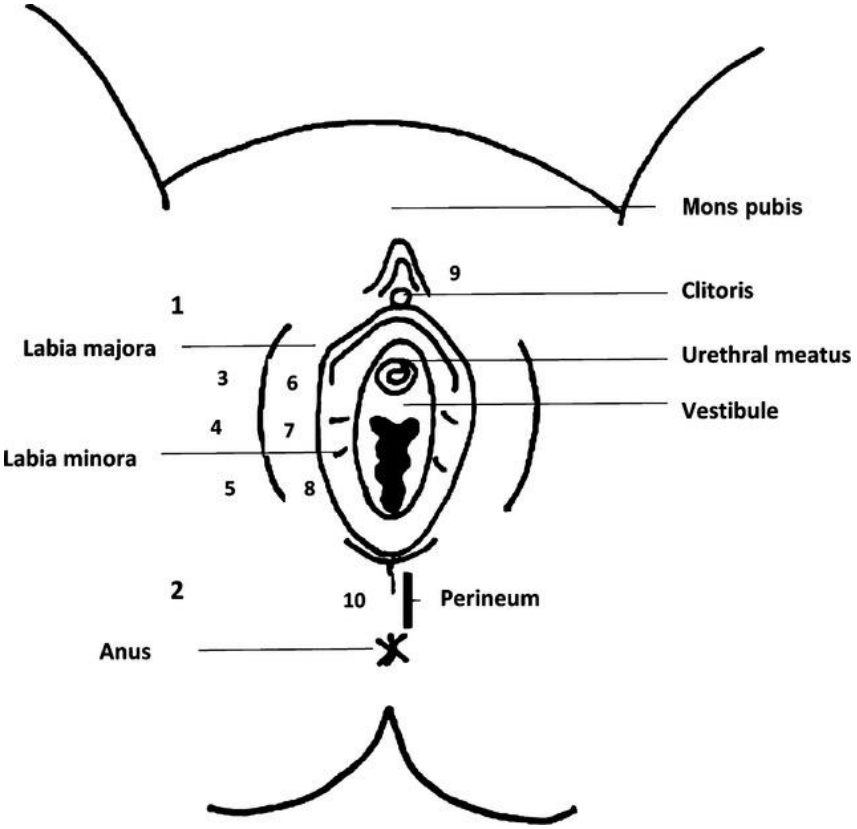


Figure 1 Picture of vulval anatomy demonstrating the Q tip test. 1,2 – inner thigh; 3,4,5 – labia majora; 6,7,8 – interlabial sulcus; 9 – clitoris; 10 – perineum (1)

Documentation Control

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	1	Feb 2020	Miss S Dixit – O&G Consultant Dr A El-Hadidy – Specialist Registrar O&G	New
	2	Jan 2023	Miss S Dixit – O&G Consultant Dr Thirugnanam - Consultant Anaesthetist	Review
Intended Recipients: All staff within the gynaecology service				
Training and Dissemination: Cascaded electronically through lead sisters/midwives/doctors; Published on Intranet, Article in Business unit newsletter; emailed via NHS.net				
Consultation with:	Gynaecologists			
Business Unit sign off:	15/05/2023: Gynaecology Guidelines Group: Miss B Purwar – Chair 23/05/2023: Gynaecology Development & Governance Committee/ACD – Mr J Dasgupta			
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