Comprehensive Treatment Essential for Vulvodynia

BY SHERRY BOSCHERT
San Francisco Bureau

SAN FRANCISCO — Vulvodynia so profoundly affects quality of life that management needs to address the physical, psychological, sexual, and relationship problems caused by the pain.

"Support, support, support" patients with vulvodynia by reassuring them that they're not crazy and validating the reality of their pain, Dr. Erika Klemperer said at a meeting sponsored by Skin Disease Education Foundation.

Refer women with vulvodynia for psychological counseling when appropriate, but be clear about why you're doing so. "It's not because we think they're crazy, but because pain makes people crazy," often triggering depression, anxiety, or other problems, said Dr. Klemperer, a private-practice dermatologist in Santa Barbara, Calif.

Vulvodynia is a diagnosis of exclusion defined as vulvar discomfort—usually a "burning" pain—occurring without any relevant visible findings or a specific, clinically identifiable, neurologic disorder. Patients may have generalized vulvodynia or vestibulodynia. An estimated 3%-16% of women experience vulvodynia during their lifetimes.

Dr. Klemperer tells patients, "I know this pain isn't in your head. This is real, and I'm going to be here to get you through this." Make an effort to understand clearly the patient's and her partner's goals for therapy so that you can guide them toward realistic expectations, because treatment may not cure the problem but should help control the pain. There are few randomized, controlled trials on treating vulvodynia, so therapy rests on expert opinion and few data.

Treatment starts with vulvar care measures, such as avoiding all irritants. Tell patients to wash the genital area using only their fingers and water, then pat dry (not blow dry). Bland emollients may help. For lubrication during intercourse, try olive oil to avoid the preservatives in commercial products.

First-line medication would be a topical anesthetic, especially for vestibulodynia. Other topical therapies tend to burn or are ineffective. Lidocaine 5% ointment or 2% gel may be used as needed or in twice- or thrice-daily regimens. Patients also can apply it 30 minutes before sexual activity but should wipe it off before sex so that it doesn't cause numbness in their partner. Dispense lidocaine gel in a 30-g tube and warn patients not to use more than 20 g per day to avoid side effects of erythema, edema, and purpura.

A 2003 study looked at women who placed a cotton ball coated with lidocaine 5% ointment on the vestibule and left it overnight, for at least 8 hours. About 75% of women were able to resume intercourse during the study, "which makes sense because we're trying to break that pain loop, break that feedback," Dr. Klemperer said.

Off-label use of systemic therapies usually starts with tricyclic antidepressants, most often amitriptyline. Tricyclics improve vulvodynia by about 60% in around half of patients. Be specific in explaining to patients that you're using these medications to try to cool down nerve fibers, and that these regimens are used for other pain problems such as diabetic neuropathy or postherpetic neuralgias.

The key to systemic therapy is to start with a low dose and increase it slowly. Dr. Klemperer usually starts a tricyclic at 10 mg nightly, increasing by 5-25 mg/week to a maximum of 150 mg nightly. Amitriptyline is available in a syrup, "so you can titrate it down to a minuscule dose. The most important thing is that they tolerate it."

Gabapentin, pregabalin, venlafaxine, and duloxetine have been used as second-line systemic therapies for vulvodynia. SSRIs have not been effective in these patients.

Chinese herbal remedies and acupuncture have benefited some of Dr. Klemperer's patients with vulvodynia, she said. She supports using complementary therapies such as hypnotherapy, meditation, and others if the patient is interested, though no clinical trials support their use. Strict dietary regimens probably are not wise in these already stressed-out patients, she added.

Injectable therapies have been tried, but the efficacy of interferon-α is questionable, so Dr. Klemperer doesn't use it. Trigger-point injections are difficult to tolerate. Pain specialists sometimes use nerve blocks for vulvodynia, and botulinum toxin has been mentioned in a few case reports.

Surgery should be reserved for patients with pure vestibulodynia with chronic, ongoing symptoms resistant to all other therapies. If vaginismus is present, treat that before sending the patient to vestibulectomy, which may alleviate symptoms in 60%-85% of cases.

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Coagulation Factors May Predict The Risk of Thrombosis From HT

BY FRAN LOWRY
Orlando Bureau

ATLANTA — Women who opt for hormone therapy to ease their discomfort from hot flashes and other menopausal symptoms often do so without knowing their risk of developing adverse effects.

Now, data from the Women's Health Initiative trials of hormone therapy (HT) may help women make more informed decisions about their risk for venous thromboembolism, should they choose to resume or start hormones.

A nested case-control study from the WHI presented at the annual meeting of the American Society of Hematology has found that excessively high levels of the coagulation factor D-dimer, in the presence of HT, significantly increases a woman's risk of developing venous thrombosis.

"If your D-dimer was in the top quarter of population distribution and you were assigned to HT, your relative risk of deep vein thrombosis was increased sixfold, compared to women whose D-dimer was low and who were assigned placebo," principal investigator Dr. Mary Cushman, professor of medicine at the University of Vermont, Burlington, said.

Dr. Cushman and her colleagues measured baseline levels of potential coagulation risk factors to see if they could pinpoint women at higher risk of venous thrombosis with hormones. They did a nested case-control study that measured baseline levels of these factors in 215 participants of the WHI who developed venous thrombosis, and 867 age-matched controls.

The women were all participants of two placebo-controlled double-blind randomized WHI trials evaluating the following regimens: conjugated equine estrogens alone, or estrogen plus medroxyprogesterone acetate. The mean age of the women in the analysis was 66 and ranged from 50 to 79 years.

Women who had low levels of protein C, free protein S, and antithrombin, and who had high levels of D-dimer, prostatic acid phosphatase, and prothrombin fragment 1-2 had an elevated risk of venous thromboembolism. The highest risk was associated with women who had D-dimer in the top quartile and who were taking hormone therapy.

If your D-dimer was in the top quarter, your relative risk of DVT was increased sixfold.

DR. CUSHMAN

In an interview, Dr. Cushman cautioned that testing for D-dimer is not yet ready for prime time because there are currently no standardized tests specifically designed to gauge venous thrombosis risk.

"There are various D-dimer assays commercially available, but choosing a proper threshold and so forth among all the different commercially available assays is a challenge," she said. "We used a particular assay in our analysis, and studies would be needed assessing other assays before using this in clinical practice."

The take home is about the additive nature of these coagulation factor abnormalities. The potential for clinical applicability is potentially there." ■

Nonhormonal Therapy Eases Postmenopausal Hot Flashes

BY FRAN LOWRY
Orlando Bureau

Treatment with desvenlafaxine succinate, an experimental nonhormonal therapy, continues to reduce the frequency and severity of moderate to severe hot flashes out to 26 weeks.

The drug, a selective serotonin norepinephrine reuptake inhibitor (SNRI), has been shown to be effective in relieving this menopausal symptom in a 12-week trial reported last year.

The current findings, from an extension of that trial, show that desvenlafaxine continues to be effective for more than 6 months, said Dr. Risa Kagan, professor of obstetrics, gynecology, and reproductive sciences at the University of California, San Francisco, and a consultant for Wyeth, which developed the drug.

"This is good news for [those] bothered [by hot flashes] and who are looking for alternatives to estrogen or hormone replacement therapy," she said in an interview.

In the continuation of the multicenter, randomized, double-blind, placebo-controlled trial, 541 women who had at least 50 moderate to severe hot flashes a week and who received 150 mg/day of desvenlafaxine maintained the significant reduction in the number of hot flashes they had achieved by week 12 of the trial (from 10 a day to 2 a day) during the 26-week study, she said at the annual meeting of the North American Menopause Society.

The improvement in hot flash frequency and severity was dose dependent. The 118 women who were randomized to desvenlafaxine 100 mg/day had a less robust decrease in hot flash frequency, and went from an average of 10 to 4 hot flashes a day by week 26. The 138 women who were randomized to placebo also saw a reduction in their hot flashes from baseline, from an average of 10 to 6 a day.

The women recorded their hot flash episodes in diaries and were assessed weekly for the first 12 months, and then every 3 weeks thereafter.

The reductions from baseline in the frequency of moderate to severe hot flashes "were significantly greater, compared with placebo, at all time points with desvenlafaxine 150 mg and at most time points with desvenlafaxine 100 mg throughout the 26 weeks of the study," Dr. Kagan said.

The most common adverse event was nausea, which improved with time. "Nausea is not unique to this agent, and is something that is associated with many of this category of drugs. But it was responsible for about 12.7% of the desvenlafaxine subjects' withdrawing from the study," she said.

Fluctuations and the eventual decline in estrogen levels in menopause may alter brain serotonin and norepinephrine transmitter levels, which may in turn produce instability in thermoregulatory function and, as a result, hot flashes, Dr. Kagan said. "[We] hope drugs like desvenlafaxine, which act on these transmitters, may provide nonhormonal relief of meno- pausal vasomotor symptoms." ■